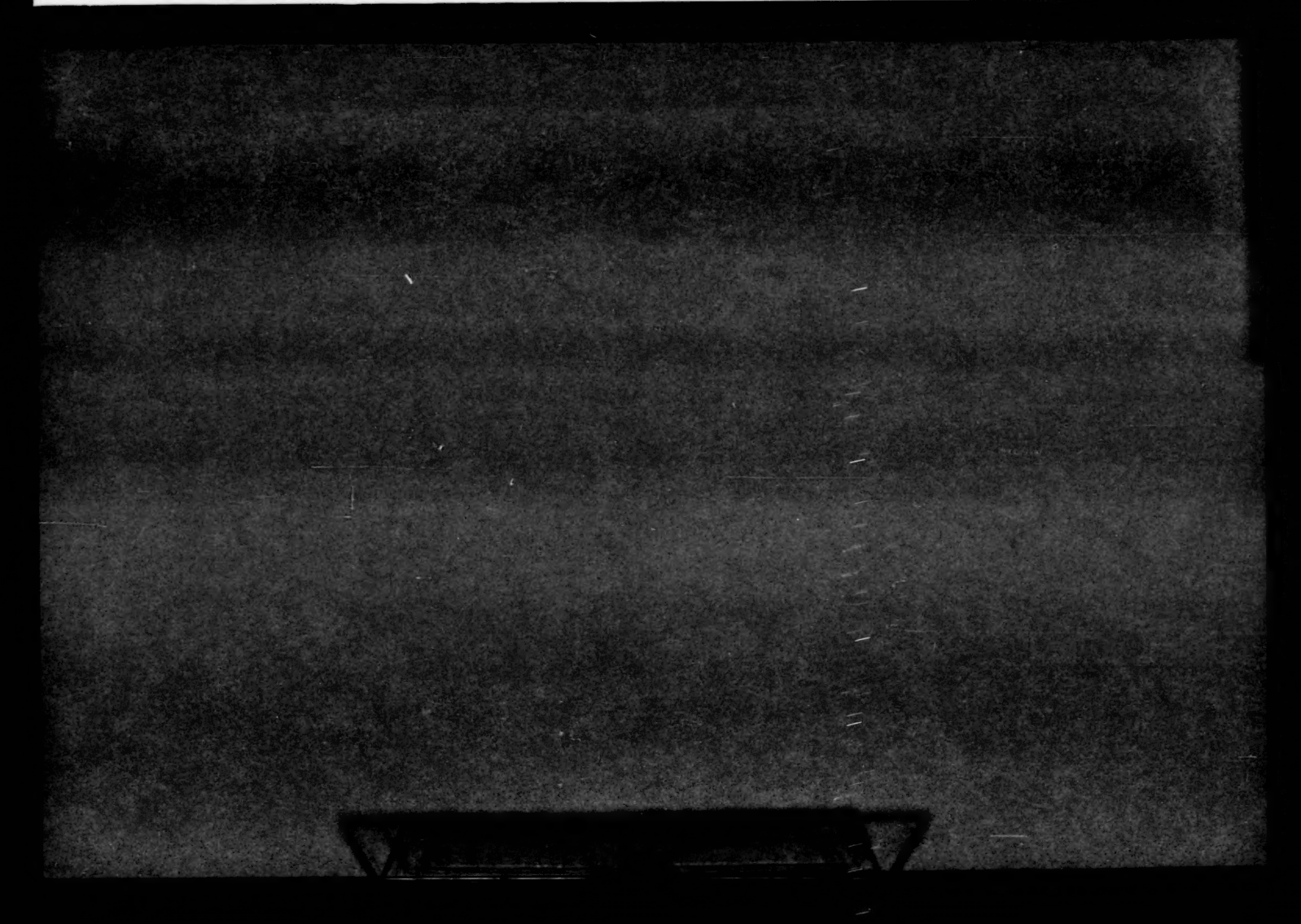


The Psychoanalytic Review
A Quarterly Educational American Journal of Psychoanalysis
Devoted to an Understanding of Human Behavior
Founded in 1913 by
WM. A. WHITE, M. D., and S. E. JELLIFFE, M. D.
Managing Editor
NOLAN D. C. LEWIS, M. D.
Issued Quarterly: $8.00 per Volume; Single Numbers, $2.25
Outside Continental U. S. A., $8.80

THE PSYCHOANALYTIC REVIEW
70 Pine Street, New York 5, N. Y.

JOURNAL OF NERVOUS AND MENTAL DISEASE

Founded in 1874 by Dr. J. S. Jewell and Dr. H. M. Bannister of Chicago, Ill.
Managing Editor, NOLAN D. C. LEWIS, M. D.

This educational monthly journal was established in 1874, and from that time on has been the chief representative of the field of American neurology and psychiatry. It represents the chief work in progressive neurology and psychiatry. A thoroughly progressive and modern magazine. Independent of cliques or special privileges.

$14.00 Yearly 2 Volumes a Year $15.50 Foreign

Orders to be sent to
JOURNAL OF NERVOUS AND MENTAL DISEASE
70 Pine Street, New York 5, N. Y.

SOCIAL AND BIOLOGICAL ASPECTS OF MENTAL DISEASE

By

BENJAMIN MALZBERG, Ph.D.
New York State Department of Mental Hygiene

Statistical analyses of the records of admissions to New York civil state hospitals provide a basis for study of these vital problems: the increase of mental disease; the relation of mental disease to age, sex, environment and marriage, nativity and race; expectation of life; the efficacy of insulin shock therapy. A valuable work of reference for the psychiatrist, the biologist, the sociologist and the statistician.

Clothbound 1940 360 pages with index

Price - - - $2.50

STATE HOSPITALS PRESS
Utica, N. Y.

Vol. 26 JULY 1952 No. 3

THE PSYCHIATRIC QUARTERLY

PUBLISHED BY AUTHORITY OF THE
NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

---

*Dr. Whitehead is serving as editor of THE QUARTERLY following Dr. Bigelow's appointment as Commissioner of Mental Hygiene.

The Psychiatric Quarterly, formerly the State Hospital Quarterly, is the official organ of the New York State Department of Mental Hygiene.

Volumes begin with the January number. Individual subscription rate, $6.00 a year in U. S. and its possessions; $6.50 elsewhere.

Editorial communications, books for review and exchange should be addressed to the editor, Utica State Hospital, Utica 2, N. Y.

Business communications, remittances and subscriptions should be addressed to the State Hospitals Press, Utica 2, N. Y.

Entered as second-class matter April 17, 1917, at the postoffice at Utica, N. Y., under the Act of March 3, 1897.

MANUSCRIPTS

Contributions from any reliable source will be considered for publication. Manuscripts should be addressed to The Editor, PSYCHIATRIC QUARTERLY, Utica State Hospital, Utica 2, N. Y.

Manuscripts should be submitted in original (not carbon) copy, typewritten cleanly, double-spaced, with wide margins, typed on one side of the paper only. Paper should be light weight, bond finish, and opaque; onion skin should not be used. The author should keep a copy for convenience in editorial correspondence.

Short summaries to conclude all articles are requested. Contributors are asked to consult current issues of THE QUARTERLY for style of reference lists and bibliographies and to submit such lists in the form used by this journal.

A short, autobiographical note is requested from each contributor.

THE QUARTERLY makes a moderate allowance, without charge to the author, for illustrations and tabular matter. Authors may be asked to meet costs of such material in excess of this allowance. Authors may also be asked to meet costs of type-setting for any extensive changes made by them after an accepted paper is in proof. THE QUARTERLY supplies 25 free reprints for each article printed, with a varying additional allowance for papers with co-authors; further reprints may be ordered at a price schedule which is set to cover costs. Reprinting elsewhere for book publication or other purposes may be arranged by agreement with the editor.

Articles accepted by THE QUARTERLY are for first and exclusive publication unless otherwise agreed by specific arrangement with the editor. Co-publication or re-publication must be arranged with the editor before publication in THE QUARTERLY.

MODIFICATIONS OF ELECTRIC SHOCK THERAPY*

BY WILLIAM L. HOLT, JR., M. D.

The modifications of electric shock therapy to be discussed here will cover some of the newer curarizing drugs that make it possible to give convulsive therapy where there are, relatively, contraindications. There will be mention also of some modifications of the electric currents employed to obtain differences in effects —without convulsive manifestations.

To recall something of the history of electric shock therapy we may note that it grew out of Cerletti's[1] work in testing anticonvulsants in laboratory animals, using electric current as the standard convulsant. He judged the anticonvulsant quality of a drug by the degree to which the stimulus had to be increased to get a convulsion. That is a key to one of the ways of modifying electric shock; the purposeful use of anticonvulsant drugs to raise the convulsant threshold as high as possible, so that seizures may be altogether prevented, even though a quantity of current is given that would ordinarily produce a convulsion.

The writer became interested in this when an epileptic under phenurone therapy was admitted to Boston Psychopathic Hospital. For the first few days, the phenurone was continued. As the patient had a severe depression, there was an attempt to produce convulsions electrically, and they could not be obtained. The threshold was too high. Yet, through the repeated attempts, the patient's psychosis was modified, so it was seen that it is possible to get some change in the emotional state without a seizure.

Those who began convulsive therapy in the days of metrazol were conditioned against metrazol therapy where convulsions were not obtained, because with metrazol, there was a terrific panic and anxiety; accompanying palpitation and hyperpnea, when insufficient dosage was given to produce a convulsion. Some of this same anxiety reaction had also been encountered in electric therapy when an insufficient stimulus was given to produce a convulsion.

However, when the dose of current is sufficiently high so that apnea is produced for 20 seconds or more, the writer has not encountered anxiety as a reaction on the part of the patient. There

*Address before the bimonthly conference of the New York State Department of Mental Hygiene at Albany, March 26, 1952.

is just as much amnesia for the treatment as if a convulsion were produced.

Attempts to get therapeutic results from electric shock by using drugs that raise the convulsant threshold had been made in Europe,[2] but the writer did not discover this until after preliminary work of his own. As is often the case, when one finds something works—and looks long enough—he finds someone else has had the same idea and has applied it. But the writer thinks no one had attempted modified electric shock with a combination of anticonvulsant drugs before Borkowski and he tried it at Boston Psychopathic Hospital.[3]

By combining dilantin and mesantoin, and dilantin and any other anticonvulsive drug that is highly efficient, patients can tolerate a greater lifting of the convulsive threshold than by one of them alone. The writer used mephenesin, one of the trade names for it being "Myanasin," others being "Tolserol" and "Oranixon." It was liked, because, when given in conjunction with dilantin, its effects were lasting enough to be efficient for the period of the treatment; and one could give enough orally to produce minimal toxic reactions of nystagmus and slight unsteadiness, but with assurance that those symptoms would disappear in 10 to 15 minutes after the treatment was over.

There is a shortcoming in this technique. One does not know how high the threshold has been raised until he finds out; and sometimes he finds out by increasing the current above the threshold and getting a convulsion. It, therefore, has obvious limitations in patients where one must not produce convulsions. There is therefore, need for a more reliable way of producing the change in emotion and feeling and thinking than is obtained by the electric shock technique if it is desired to produce the change without any muscular rigor.

Bennett,[4] in 1940, introduced curare, at first rather crudely, partially purified. As its effectiveness and usefulness increased the demand, the pharmaceutical companies produced a purified crystalline product, d-tubocurarine; and its use has long been a fairly well-standardized method for preventing a convulsion, not by raising the threshold of the convulsion stimulus, but by blocking the peripheral manifestations of the seizure.

*Holt, W. L., Jr., and Borkowski, W.: Drug-modified electric shock therapy. PSYCHIAT. QUART., 25:4, 581-588, October 1951.

There were disadvantages to the technique when only d-tubocurarine was used, the chief of which was that the patient was sometimes "scared to death." There were some unexplained deaths occurring before the electric stimulus was given. Some of these patients in particular insisted they were going to die if they received the injection, and they did in fact die. There seemed to be no reason other than fear.

The writer would say that, if a muscle-paralyzing drug is given without an anesthetic, there is a subjective experience on the part of the patient which is fear-producing. The patient who cannot speak, cannot breathe in air, cannot make his panic known to you, has an inner turmoil which is reflected by a rise in pulse rate and rather restless movements of whatever muscles are still capable of moving, and the writer thinks it is inhumane, as well as dangerous, to give a muscle-paralyzing drug without an anesthetic. So the combination of d-tubocurarine and some quick-acting anesthetic was a natural development.

The advent of nembutal—and then sodium pentothal—met fairly adequately the need for a quick-acting anesthetic. It is unfortunately somewhat difficult technically to do multiple vein punctures, to give the d-tubocurarine first, then sodium pentothal, and then antidotes intravenously. One would like to give, in one injection, if possible, as many drugs as are going to be given.

The fact that d-tubocurarine and pentothal solutions are usually not miscible—that is, one precipitates out in the presence of the other—has been something of a handicap to the extensive use of the two drugs together.

The preparation of d-tubocurarine is an expensive process. It is derived from crude products that are hard to obtain. There has, therefore, been a search for synthetic substitutes. The first efficient one—that has in some measure supplanted d-tubocurarine—is decamethonium bromide or "Syncurine."[5] This drug is a 10-carbon-atom chain, with a methyl amonium bromide radical on each end of the chain. It is easy to standardize. It is chemically easy to make. It is miscible with pentothal, so it is simple to give both in one syringe.

There is the disadvange in its use that there is no natural antagonist available with which to counteract the effects. One must allow the body to eliminate or metabolize the drug, and that takes a varying length of time. Ordinarily, if enough syncurine is given

to stop respiration and to make all muscles of the skeletal type flaccid, it will take an average of 10 minutes for respiratory activity to resume at the end of a seizure.

This requires time in treatment and requires application of considerable amounts of oxygen, which raises the cost somewhat. The chief cost is the time, and the wear and tear on the nervous system of the doctor administering the drug, when there is no natural antagonist available and he simply has to wait, because sometimes the drug retains its efficient suppression of muscular activity twice as long as for the average case. And if a doctor is waiting 20 minutes, both he and his other patients feel the strain.

Some French chemists found, in 1946, that other drugs—chemically somewhat resembling curare, but somewhat simpler—could be synthesized, and that they had curare-like effects. In 1949, these workers were sufficiently satisfied with the drug then developed to license its manufacture in England, and ultimately in the United States, and it is now on the market under the trade name of "Flaxedil" (Lederle). Flaxedil is essentially a six-carbon-benzene ring with three long radicals attached to this ring, each radical being a diethylaminoethoxie radical, with a triethyl iodide radical at the end of the chain. It is known as tridiethylaminoethoxybenzene triethyl iodide, so one can see the convenience in calling it flaxedil.

One of the first reports on its use clinically came out in *The Lancet* in 1949, under the authorship of Mushin, Wien, Mason and Langston.[6] The authors noted that it had a somewhat greater margin of safety than d-tubocurarine. They reported that it was less histamine-producing, less apt to produce bronchospasm and respiratory obstruction.

The administration of curarizing drugs has necessarily been complicated by the problems of the anesthetic used, and it has been pointed out why the writer thinks the anesthetic is essential. Most workers probably are familiar with the fact that pentothal sometimes produces cough and some evidence of bronchial spasm while it is being injected.

If a curarizing drug is used which adds to the tendency to produce bronchial spasm, there is a double hazard; and if one can use a curarizing drug that is free of histamine-producing effects, a drug that does not increase the dangers of bronchospasm, it should obviously be preferred. Syncurine has this advantage to a con-

siderable degree, but flaxedil is superior in its freedom from histamine and bronchospasm reactions.

No matter what curarizing drug is used, it must be remembered that pentothal itself can produce respiratory obstruction, and it must be emphasized that anybody using these drugs in amount sufficient to produce respiratory obstruction must know how to deal with that condition. Equipment and knowledge of how to use it should be at hand, so that visual direct intubation can be done by someone on the treatment team at the time respiratory obstruction develops. Obstruction of the air passage below the pharynx is distinctly infrequent; but, when it occurs, it can be the cause of a fatality. It does not require a great deal of experience to be able to pass a tube for its relief.

The writer thinks the drugs under discussion should be used only in hospitals where anesthetic departments and anesthetists can give training to anyone who is doing electric shock with drugs. With that safeguard, it is possible to treat people who otherwise should not receive convulsive therapy.

Some of the physiologic effects of flaxedil itself should be discussed, as they enter into the problem of choosing the muscle-relaxant drug best suited to the particular patient to be treated. If the patient is hypertensive, with blood pressure well above 200 systolic and 140 diastolic, it should be realized that when pentothal anesthesia is given, there is almost inevitably a considerable drop in blood pressure. The cardiac consultant, in considering whether the patient should in fact have pentothal and curarizing drugs, should consider whether the patient can tolerate a drop of 50 to 60 millimeters of mercury in the blood pressure at the time the anesthetic is given. Most patients can, but occasionally one gets into some trouble.

If a person has angina and some coronary incompetence, a drop of 50 points in the blood pressure may lead to some occlusion symptoms. So one of the untoward accidents that may develop in the course of using these curarizing drugs is that one may precipitate a coronary attack—long before electric shock is given—just as soon as the pentothal is administered.

It is fortunately not a frequent occurrence. The writer has heard of only one such attack in several hundred patients treated with flaxedil, every one of whom had relative contraindications to giving ordinary electric shock.

Flaxedil increases the pulse rate; and if one wants to minimize the change in pulse rate—syncurine is superior to flaxedil in this respect. Syncurine allows less initial muscle jerk with the electric stimulus than does flaxedil, sometimes a real advantage.

The electric shock, as we know, stimulates the central nervous system, including the vagus nerve centers, so that cardiac arrest is described by Cerletti as an invariable manifestation of the electrically-induced convulsion.

If the patient is atropinized, that "invariable cessation of cardiac activity" does not occur. It takes a considerable amount of atropine in some patients, even up to 1/50 grain. The writer personally gets too much inner turmoil when he cannot feel a pulse for 20 or 30 seconds, a thing which may occur when one is giving electric shock and not atropinizing the patient.

One death at Boston Psychopathic Hospital occurred in a person with some EKG evidence of impaired conduction, but he was declared suitable by the consultant cardiologist for electric shock without any modification of technique. Unfortunately, the cardiologist was wrong. The patient's pulse stopped immediately with the electric stimulus, and did not start again. Adrenalin, administered intracardially a minute or so after no pulse could be found, started the heart for 30 seconds, but it stopped again, presumably because of the effect of the electric shock stimulus. Thereafter, atropine was never omitted in any case. The writer thinks atropine is a drug that is essentially harmless to almost everybody who takes it; and he would rather take the risk of giving it than the known risk encountered in not giving it.

When curarizing drugs are given, atropine is important because electric shock has the same effect on the vagus nerve regardless of the peripheral blocking of skeletal muscles. Atropine has another function, of course; it suppresses the salivation. The less obstruction of airways by excessive mucus, the better. The author's routine has been to give 1/75 grain of atropine subcutaneously half an hour before the treatment, and a further amount of atropine at the time the antidote to flaxedil is given.

If d-tubocurarine or flaxedil is given, prostigmin is the physiological antagonist. If the writer gives 100 mg. of flaxedil, which is an average dose, then he gives 2 mg. of prostigmin, together with 1/100 grain of atropine intramuscularly just before the electric stimulus is given the patient.

With that technique, most patients resume breathing by the time the seizure is completely over, and it is rare that one has to give oxygen for more than one or two minutes, usually only because breathing is shallow at first.

To recapitulate the effects of flaxedil: It increases the pulse rate 10 to 40 beats a minute. That occurs during the injection of pentothal and flaxedil. The blood pressure often drops, especially in the hypertensive patient; but ordinarily does not drop below 100 mm. In persons with normal blood pressure there is usually no drop at all.

The modified seizure which results when an electric stimulus is given will still give a rise in blood pressure, so the procedure outlined is not an absolute protection against a rise; but the writer thinks that it is minor, compared to what occurs in an unmodified seizure.

The writer does not know anyone who has been able to measure the peak of the arterial pressure in an unmodified seizure. When the seizure is modified very little by small doses of curarizing drugs, one can often find that the blood pressure is higher than the manometer will read—in other words, in excess of 300. If adequate amounts of curarizing drugs are given, the maximum rise is usually in the neighborhood of 50 to 60 mm. of mercury. This usually brings the pressure up in a hypertensive patient only to about where it was before starting the pentothal injection. Thus the writer would say he thinks curarization has protective value even though there is a sudden rise in pressure at the time the convulsion begins. That rise in pressure is independent of the amount of peripheral musculature showing any response to the stimulus; that is, it will continue to show a rise even though the only manifestation one can see of the seizure is a little twitching of the eyelid muscles.

When, instead of flaxedil, decamethonium bromide is used, there is no pulse rise. There is the same change in blood pressure as when flaxedil is used. One can get exactly the same degree of modification with the two drugs. There is the same problem of not being able to estimate in advance precisely how much modification is going to occur, regardless of which, if any, of the curarizing drugs are used—as far as the writer has been able to find by experience.

In general, the more muscular the person, the better his physical conditioning, the more muscle-relaxant is needed. It is not satisfactory to go by body weight. If that weight is chiefly fat, then there may be very profound relaxation from a rather small dose. The writer has often given persons of the same weights the same doses, and gotten far more modification in one than in the other; but results are essentially reproducible from treatment to treatment.

Especially is that true of flaxedil. Once one has learned how much to give, the patient needs very little change in that amount over the course of treatment. This is not so true of syncurine, or decamethonium bromide, as there is some degree of tolerance developed by a fair proportion of the patients. Perhaps a third of them will require twice as much syncurine at the end of a course of treatments as they needed in the first two treatments.

The writer has not seen that change in tolerance with flaxedil, though he has seen a slight increase required—never more than 20 mg. more or 1 cc. more, which is relatively a change of 20 per cent rather than 100 per cent, as may be required for syncurine.

When a treatment unit is set up to make use of these curarizing drugs, a rating scale is needed, for recording the degree of modification. The writer does not think there is any special virtue in his own rating scale, but believes some such scale needs to be used so that successive physicians on successive treatment days know whether to increase or decrease the amount of drug given.

In determining when to proceed with treatment at the first injection, the writer advocates giving a small enough amount of pentothal the first time, say 200 to 250 milligrams, so that at the end of three minutes the patient can make some response to a shouted command. It can be judged, from the strength of the patient's co-operative response, how weak the muscles are. So, after giving the first injection, the writer shouts in the patient's ear at the end of two minutes, "Squeeze my hand," having put some of his fingers in the patient's hand. At three minutes, he shouts: "Raise your knee." If there is a strong hand grip, one can be pretty sure that there will be only minimal weakening of the seizure. If there is merely the slightest, visually perceptible, change in the movement of the fingers or knee, it is pretty certain, for example, that there will be no tension on any severed nerve or tendon, which may be the indication for giving the drug.

The writer calls it Modification Four, or maximum modification, if he has to study the eyelid muscles carefully, and if they are the only visible indication of any seizure having occurred. It is called Modification One if the seizure is strong and arms or legs cannot be bent during the tonic phase.

It is called Two Plus if one can, with effort, overcome the tonic phase in either arms or legs, and Three Plus if the legs and arms are limp but there is enough clonic movement during the seizure to make the major joints move off the table; and Three and a Half Plus if there is just a weak clonus in the hands and feet. That is the level usually aimed for.

The indications for which the writer has used curarization are primarily physical trauma and cardiac disease. Physical trauma includes such things as thoracoplasty in a tuberculous patient who may be suicidal and extremely agitated and depressed, won't stay in bed and cannot be controlled in the first few days after the operation. With sufficient curarizing, one can give electric shock and get the patient over that state of mental turmoil that is interfering with surgical care. The indications include such things as thyroidectomy, where the fresh scar should not have tension on it; such things as a cesarean that is only a couple of days old; and a fair proportion of self-inflicted traumata which may mean hand tendons and nerves cut severely—cases in which, after surgical care has been given, the patient may still wish to die.

The writer clearly recalls one such self-injured man who reached over to the dressing tray where the nurse had a bottle of merthiolate. With the arm that was not ruined by self-inflicted wounds he quickly grabbed the merthiolate and managed to drink some of it before the nurse could interfere. When a person is that severely depressed and anxious to die, one needs to undertake some active treatment as a calculated risk. It is less dangerous for the patient to give him shock treatment with use of a curarizing drug than to let him try every means at his command to end his life.

Recently the writer has had some experience with tracheal wounds, with persons who have severed their tracheas completely. The day after one such slash, after it was sewn together, it was possible to give electric shock therapy successfully to such a depressed person, with no damage to the wound. In such a situation, the writer thinks these relaxant drugs should be used, though it is obvious that there are some risks. The risks involved are es-

sentially those of giving a general anesthestic, and of what may happen to the cardiac mechanism when an electric stimulus is given to the brain.

In addition to prostigmin there is now available a newer synthetic antagonist, either to flaxedil or d-tubocurarine. It is produced under the trade name of "Tensilon" and is put out by La-Roche. It is free from the disagreeable side-effects of excessive salivation and is, therefore, preferred by some workers in this field. It has the disadvantage, however, that it is not effective when given intramuscularly; its use involves giving another intravenous injection at the end of the treatment as soon as the seizure is over. The writer personally finds that sufficient nuisance so that he prefers the prostigmin technique, for it is easier to give an intramuscular injection. The limitations of the intravenous route for medication are well known: There is the technical one, for after a certain time there may be difficulty getting into a vein, and it may take a lot of time. Occasionally, this leads to complications from thrombosis in the veins and thrombophlebitis. That is one of the disadvantages that led to the superseding of metrazol therapy by electric shock therapy.

Up to the present moment, the writer has not had any deaths in patients who have had syncurine or flaxedil, with pentothal anesthesia. But there have been some uneasy moments before the electric shock was given, in relation to bronchospasm—especially with "Metubin." The writer has had so many respiratory difficulties with this drug that he has given it up entirely. Some colleagues report similar experience. The writer does not think that metubin has any advantage, and it has had a high incidence of bronchospasm complications among his patients.

So much for curarization, in contrast to anticonvulsants that raise the convulsant threshold.

Nonconvulsive Electric Shock

There are patients with anxiety reactions of an acute type, where pentothal and electric stimulation without convulsions may give dramatic relief. Sometimes one can get the same relief without pressing the electric shock button, simply by giving the pentothal, but fairly often not. The technique is to give enough pentothal so the patient is at first unconscious, with no response to touching the

eyelash, and then give electrical stimulus of a type of current that does not readily produce convulsions but will make the musculature rigid.

After anywhere from two to 30 seconds, the writer reduces the current from a level just below convulsant threshold to one that allows the musculature of the chest sufficient freedom to move so that breathing goes on spontaneously. The pentothal is exhausted by the combination of muscular work and general metabolism at a fairly rapid rate; and, usually within about three minutes, the patient becomes aware of the electrical stimulus. The writer believes that in some measure this accounts for greater improvement in some patients than when only pentothal is given.

The subjective experience that patients tell of, if they recall the treatment at all, is that it is like bombshells going off in their heads, or red-hot needles passing from side to side through their heads. The writer and his colleagues have occasionally taken as much of the current—self-administered—as they could stand, just to see what it felt like, to judge whether the anesthetic was really essential. The writer would say that a person without anesthetic cannot stand more than about half a milliampere of current; and it does feel like red-hot needles with flashing lights in front of the eyes. So the writer would say that the anesthetic is, to him, an essential in the humane treatment of the patient; he does not think one should inflict unnecessary pain upon anyone.

In persons with depression and tension symptoms, the depression may become more evident while they are going through a course of pentothal, subconvulsive, electric stimulation treatment. Alexander[7] in Boston, pointed that out first of all, and said it was often necessary to give a convulsion to such a patient to relieve the depression. But as one knows, it is not infrequent that electric convulsive therapy does not relieve tension on the part of the patient, and it is possible in such cases of agitated depression, or in tension states with depression, to bring about grand mal seizures on some treatment days, and nonconvulsive treatments on other days, and eliminate both the depression and the tension. Reports in the literature are quite inadequate to give any firm appraisal of the usefulness of the subconvulsive technique, but the writer has seen enough response in certain patients to make him continue to look for the best field for its use.

Undoubtedly, some of the effectiveness is the psychological effect of having a fairly-complicated procedure carried out, but the writer thinks that some of the results may be specific in terms of the location of the current and the type of current used.

Albany Hospital
Albany, N. Y.

REFERENCES

1. Cerletti, U., and Bini, L.: L'Electroshock. Arch. ges. neurol. psichiat. e psicoanal., 19:266-268, 1938.
2. Sogliani, G.: "Electric-absence" and electric partial attacks. Zeitschr. f. de ges. Neurol. u. Psychiat., 173:757-765, December 1941.

——:Plattner, P.: Surgical complications from electric shock treatment and their prevention by mesantoin. Monatschr. f. Psychiat. u. Neurol., 118:192-227, September-October 1949.

3. Holt, W. L., Jr., and Borkowski, W.: Drug-modified electric shock therapy. PSYCHIAT. QUART., 25:4, 581-588, October 1951.
4. Bennett, A. E.: Preventing traumatic complications in shock therapy by curare. J. A. M. A., 114:322-324, January 27, 1940.
5. Holt, W. L., Jr.; Rinkel, M.; Nicholson, M.; and Solomon, H. C.: Decamethonium bromide (C-10) in electric convulsive therapy. Am. J. Psychiat., 107:821-823, May 1951.
6. Mushin, W.; Wirn, R.; Mason, D., and Langston, G. T.: Curare-like action of tri(diethylaminoethoxy) benzene triethyliodide. Lancet, 1:726-728, April 30, 1949.
7. Alexander, Leo: Non-convulsive electric stimulation therapy: its place in treatment of affective disorders, with notes on reciprocal relationship of anxiety and depression. Am. J. Psychiat., 107:241-250, October 1950.

AILUROPHOBIA AND ORNITHOPHOBIA

(*Cat Phobia and Bird Phobia*)

BY LOUIS S. LONDON, M. D.

Introduction

Two of the rare examples of ailurophobia and ornithophobia appearing in psychoanalytic literature are presented by Wilhelm Stekel. The analyses of both cases were made in the early stages of psychoanalytic history, and in the panorama of the new science represent fragmentary and tenuous asides, mere observations and clues, as Stekel and other major pioneers explored and cultivated larger, classic areas.

Consequently, it is not surprising to see that in neither of these cases is much revealed about mechanisms. Stekel found that a cat phobia in one patient, a 48-year-old woman, represented a paraphilia, and that the woman identified herself with the cat, an embodiment of infantile, criminal ideas, a force which repressed sexual interest. The analysis, which was probably very short, was not completely successful, but some improvement was recorded. The other patient, a man of 41, had a bird phobia in which a large homosexual component and identification with the father were found.

Case History

The present paper is concerned with the history of a 25-year-old woman who feared both cats and birds. Prolonged analysis—interrupted by a surgical operation—showed that her phobias symbolized fear of genitals and constituted the cause of her marked sexual frigidity.

Family History

Her father died of exhaustion following an attack of manic-depressive psychosis at the age of 55. Her mother is 50 years old and apparently normal. An older sister and a younger brother are also well-balanced emotionally. A paternal cousin was described as "peculiar."

Relationship to Parents

The patient has never been closely attached to her parents. She has always disliked being touched by her mother, or being taken

by the arm by the woman, or being in close physical proximity to her. She never wants her mother to visit her; and when such visits occur, she soon wearies of the mother's presence. She cannot confide in her mother. She regards this parent as a maid or "piece of furniture" to be used only as a convenience. A dream in which *the mother is pictured as a cat* integrates these attitudes, and reactions.

When, at puberty, she first learned that her parents had sexual relations with each other, she was revolted. Except on one occasion, when the mother told her that at the time of her own marriage she had known nothing about sex life or impregnation and childbirth, sexual matters were absent from all discussions between mother and child.

Life History

The patient was graduated from high school at 17, and then studied stenography for several months at a business college. Now and then, she thought of entering college, but after her father died she had to go to work. She was always able to find employment and was efficient in her duties.

She had been baptized a Baptist, and during childhood had faith in her religion, prayed regularly, and believed in a hereafter. Later, her faith weakened and she joined another church.

Stubbornness and inability to admit she was wrong characterized her childhood. She had usually persisted in arguments until she got her way. She was sadistic toward her family, parents and siblings, and often said things to them which she later rued. During early childhood she sometimes lied to her mother about trivial things. At the age of 14 her home life seemed so difficult that she wanted to leave the family. Her father took her to a neighbor's house, but next day the girl returned to her own home.

Sexual History

She remembers that her brother was born when she was six years old. At the age of 10, she touched the penis of the little boy who was then four. She often saw her brother playing with his penis, and remembers her mother continually stopping him.

A homosexual trauma occurred when the girl was between six and 10. She vaguely remembers that, while she was playing with

her sister and another little girl, a hose was placed near her clitoris—but she does not recall having experienced any feeling. Of related purport, she recalls that between the ages of five and nine she thrust a bicycle pump between her legs.

When she was nine or 10 she pressed a handkerchief between her legs as a "menstrual pad," and this act was accompanied by an exciting sensation. She does not know why she used the "pad" in this manner, and she does not remember having seen anyone else performing this action. However, it is probable that she had seen her mother apply a sanitary napkin.

At home there was an omnipotent taboo on sexual knowledge. It was outside the home that the girl, at puberty, violated this taboo. She listened to another girl tell her of sexual intercourse in such gripping language as: "A part of a man goes into a part of a woman." She listened, as the girl, whose father was a physician, told her "how babies are born." She went to the office of the girlfriends' father, and there the two girls often searched through medical books for more detailed knowledge of sexuality.

When the patient first menstruated, the mother exclaimed, "Thank God!" At the age of 16, the girl had fantasies of young women acrobats seated on the tops of poles. They would do splits on the tops of the poles, and then would be elevated. Erotic sensations were produced by the fantasies. Then the patient would rub her clitoris and have orgasms. After she was married, she noted that there was a change in location of the orgasm from the clitoris to the orifice.

Before marriage she had a brief affair during which she practised sexual deviations, *soixante-neuf* and fellatio. Once a man invited her to his home where he raped her. She declares that she was powerless to resist his advances although she hit him and struggled vigorously.

During analysis, the patient, supporting her procrastination by a plea of amnesia for sexual events, did not disclose anything about sexuality until 75 sessions had passed. She was so reluctant to give information about her sex life that she sent the analyst a letter reporting some of her experiences.

The analyst, however, ignored the letter and waited for the woman to speak freely of the matters she had described in writing.

Relationship to Homosexuality and Heterosexuality

During her childhood, she associated with the opposite sex, but her relationships were seldom close. She did have two love affairs, and one of them reached the sexual level. But usually her interest in the opposite sex was based on a latent homosexuality. She wanted to be fondled and she desired pleasures, but she did not want to accept the consequences of such pleasures. Sexual intercourse seemed ridiculous to her, and she often wished that sex were nonexistent so that she could lead an asexual life. In order to find out what sexual feelings were, she had her first intercourse—but she was entirely frigid. Even with this man whom she expected to marry, intercourse was revolting. Even forepleasure was not always present. She often expressed a desire to live in sexual abstinence with the man.

The maternal instinct was absent in her, and she wanted to be a career woman. She disliked cooking and housework. Childbearing seemed to her to be laden with horror. To her, marriage seemed no better than death—but she wanted to marry.

She became frightened whenever she saw a strange woman. This fear, representing fear of latent homosexuality, was similar to her fear of birds (see the discussion of symptomatology). It was especially strong when she was in the presence of women who were angry. Whenever she saw two women arguing, she became apprehensive. She particularly remembered fear, resembling that she had for birds and cats, when an irritated woman reprimanded her because smoke from the patient's cigarette drifted against her face.

She always hated "feminine" women and such feminine wearing apparel as ruffles and frills. She intensely disliked shopping for women's clothes. She thought it would be much easier to buy men's clothes, although she also thought that men found the purchasing of clothes less interesting than the women did.

Symptomatology

Her chief phobias were centered about cats and birds. The patient could not endure the touch of bird's feathers or cat's fur. When a bird or a cat was near her, she became hysterical and tense. The anxiety state sometimes became so strong that she could not move. The time of the onset of these phobias has not been ascertained, but apparently they followed a scene in which

she saw a hen's head cut off on a farm. Until she was seven, however, she was not affected by such phobias, for at that age she was fond of perusing Burgess' *Study of Birds,* a book which was profusely illustrated in accord with its text on popular ornithology.

During childhood, the patient was fretful and hysterical. Her sister once chased her around the room with a feather duster; and, thereafter, she had to submit to all of the older girl's commands. At about the time of her puberty, her father said she was too fat, and she responded by going on a diet. During adolescence she wanted to be left alone. Feelings and ideas of wanting to be secluded increased after she was 17. Hysterical manifestations during her 'teens were elicited. At 16 she became hysterical when she saw a kitten running toward her. At 17 she had a fainting attack. "Everything went black and then I fainted." She does not remember how long she was unconscious, but before she was revived she had an involuntary evacuation of the bowels. When she was 17, a cat chased her, and she became hysterical and jumped onto a chair. At 20 she had to remain in bed for two weeks, and this episode may have been hysterical.

In analysis, her recollection of the times at which events took place was poor. She was resistant and complained of a period of retrograde amnesia. She could "place" the incidents that she related only by recalling where she lived at the time.

For many years, she has had "nervous headaches" which start at the top of her head and radiate to her forehead. This condition is aggravated by any motility of her head. She cannot endure wind blowing against her hair. The headaches have lasted for as long as a week.

Her frigidity manifests itself in an interesting way during her menstrual period. At that time, she often craves sexual intercourse. The menstruation is used as a protective mechanism to prevent her from having heterosexual activities, and she occasionally has metrorrhagia.

Occasionally she has sleepy spells and emotional moods which are hysterical in origin. She cried when she watched the moving picture of *Romeo and Juliet.* After an argument with her lover she thought of jumping out of the window.

In the middle of analysis she developed acute abdominal pains. The possibility of a psychogenic etiology was considered, but the acuteness of the pain, coupled with the fact that her mental con-

dition had improved, made this improbable. She was sent to an internist who made a diagnosis of appendicitis and advised an operation. He scoffed at the psychoanalytic treatment she had been getting.

A skillful surgeon performed an operation. He found that the cause of her acute pains was a cystic ovary, but he also removed the appendix which he admitted was not pathologic. The surgical intervention, including time for convalescence, took about three months. It created havoc with the analysis. The patient returned to the analyst with doubts as to the psychogenesis of disease implanted in her mind by a celebrated internist. Some two months were required to re-establish a positive transference. The patient, herself, remarked that she had slipped back about a year in analysis. Her resistance continued at infrequent intervals, and she "forgot" her dream material. She later admitted that she fabricated and manufactured dreams on awakening. Fabricated dreams are, from a psychological aspect, just as important as dream material, but they are always evidence of resistance to analysis.

Psychodynamics

She brought many dreams of transvestism which involved both sexes. Often in these dreams she saw herself dressed as a man. *She goes to a party with a girlfriend and finds she is dressed as a man.* She brought several similar dream fragments during her treatment.

Whenever she saw torture scenes on the screen she would turn her head, but she had a hidden sadism. The following dream shows her sadistic and bisexual conflicts: *She is on her way to a night club with a girl. They have just left another girl. They were supposed to hide a bracelet, but when they reach the night club the bracelet is gone. There is a vague murder scene in the club. Some man is stabbed with a knife.*

The homosexual component is disclosed in her association with the girl. The bracelet is a well-known sexual symbol. The patient craves the death of her heterosexual component so that she can lead a homosexual life. The other girl depicted in the dream is her best girlfriend.

Her sadism was hidden in her fears of strangulation and in horror scenes. She could not bear to have anyone touch her neck.

When her lover placed his arms about her neck she would develop hysterical outbreaks.

Her resistance to analysis is shown in the following dreams: *Some man is in prison. He tries to fight his way out, but they will not let him.* Associating, she says that *she* is the *man,* and the *prison is the analysis. Again*: *She is on the edge of a body of water. She looks through the telescope and sees two different kinds of water. She sees waves, but it is hard to differentiate between the different kinds of water.* The *telescope* represents *analysis.* The patient has a scotoma which prevents her from seeing her conflict clearly.

The bisexual element was dominant in this patient. In free associations, she frequently told of her protest against her womanhood. Her libido was so fixated on herself that she could not expend it on her family or her friends. She had always been interested in saving money. To her, money symbolized love, which she carefully kept to herself.

There were no other traumata shown except those recorded under "sexual history." Early traumata, fixations, or castration elements cannot always be elicited. Her sexual life was infantile, and never reached the mature heterosexual level. Her mother's affection had spoiled her, and it is not difficult to understand why her sister often referred to her as a "brat."

As is true in other cases of sexual frigidity, the maternal instinct was lacking in this patient because of a diminution of the heterosexual urge.

The cats and birds were symbols of the phallus, and she feared them because she feared heterosexuality. This is interwoven with her sexual frigidity with the consequent clinical picture shown in this paper.

Epilogue

The writer had an occasion to interview this former patient recently—14 years after the conclusion of the analysis. She continues married. She is no longer afraid of cats and birds. Her sexual disinterest is maintained, however, and although she is only 39 she is fearful of the approach of the menopause.

1500 New Hampshire Ave. Northwest
Washington, D. C.

PERSONALITY REINTEGRATION BY LOBOTOMY AND PSYCHOTHERAPY: A CASE REPORT*

BY FLOYD O. RING, M. D.

A 51-year-old man who had been severely ill for 30 years and was considered completely hopeless made an astonishing recovery after a lobotomy and nine months of intensive follow-up treatment. The case has demonstrated: (a) that an apparently hopeless mental patient, as will be described, can recover; (b) the role of lobotomy in the treatment of a patient of this kind; (c) the extent to which it is possible for a patient to reflect on and alter his thought processes after lobotomy; and (d) the importance of an intensive treatment program beginning immediately after lobotomy.

A remarkable feature of this patient's illness is that its evolution, the final symptoms, symbolizations and restitutive phenomena show such close correlation with Freud's report of the Schreber case.[1] His illness began at the age of 20, and for 22 years the community tolerated his anti-social behavior until repeated homicidal and suicidal attempts made it mandatory that he be permanently hospitalized. Then, for eight years he was treated on closed hospital wards, remaining severely disturbed and exceedingly difficult to manage. Hope for any improvement had been given up because of the nature and duration of his illness, his age, possible organic brain damage, and an absence of anyone who could help him readjust outside the hospital.

Two years ago, a lobotomy was performed in an effort to relieve some of his acute suffering. The operation was followed by nine months of intensive psychotherapy, at the end of which time clinical examinations and psychological retesting showed that all signs of mental illness had completely disappeared. He was discharged from the hospital and began an active, useful and happy life in the community. Because of his new friendliness, gratitude, and appropriate behavior, his family and friends are now enjoying his company more than they ever could before.

*Sponsored by the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the author are a result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Clinical History and Examination

Sickly and asthmatic as a child, L. usurped about all of his mother's attentions, though there were seven siblings. The mother was a hard-working, moralistic woman, and the father was a quiet laboring man who spent his spare time gardening or fishing and paid little attention to the growing children. The patient did not start school until the age of seven "because he was weak," continually plaguing older people with his excessive demands. After starting school he had frequent conflicts with teachers because he insisted he was right even when he had made obvious mistakes. When the patient was 11 years old his younger brother became permanently disabled and was in more urgent need of the mother's special care.

At this time, the patient "outgrew his asthma and became a robust and aggressive youth." After finishing the eighth grade, he quit school to become a carpenter and cabinet maker. He was rather successful, and turned his earnings over to his family with whom he continued to live. About the only social activity in which he engaged was his regular Sunday church attendance in the company of his devout Protestant parents. As far as is known he never had girlfriends and was sexually abstinent until his induction into the military service at the age of 18, during the first world war.

In the service he made a good record and was promoted to the rank of first lieutenant while overseas. Following his return home he resumed his former occupation. Though he was again doing excellent work he had become irritable and restless, and was constantly seeking to change things in his environment.

At the age of 20, he was married, but marital relations were soon strained because of his irritability and "excessive" sexual demands upon his wife. He was jealous of his wife and charged that she was "immorally" interested in other men, although at the same time he was unduly attentive to his wife's married sister. In spite of these difficulties at home he was respected by his employer and fellow-employees and was elected president of the local labor organization.

Crying spells and alcoholism at the age of 25 interrupted his heretofore regular attendance at work, and he was forced to quit his job. He spent much time assisting in political campaigns and stayed away from home until late at night, or failed to come home

at all. Sexually promiscuous, he contracted gonorrhea which he gave to his wife. He sometimes banged the children's heads together or whipped the children until they bled. He threatened his wife with ice picks, which he kept hidden about the home, and when he was 32 he attempted to kill his wife by choking her.

Following the attack on his wife, he was hospitalized briefly for psychiatric observation. The records describe him as "homicidal, suicidal, depressed, and suffering from delusions of persecution." He improved quickly without treatment and, after his release, received a position on the police force, a reward for his assistance in political campaigns.

On the police force, he became a well-known figure about the city and established a reputation for himself by his uncompromising decisions. After three years he lost this job when his political party went out of power. He took numerous jobs which he soon quit because he could not get along with other people or felt he was "too high type" an individual to do the work. At the age of 36 he became a state highway patrolman but soon lost this job because he was discourteous and abusive to minor law violators, drank on duty, and picked up girls in the patrol car. This was his last job.

His social adjustment completely deteriorated, he no longer showed any evidence of interest in his environment, and he pursued a life of vagrancy. He wandered apathetically from place to place, an irresponsible and neglected person. His friends could no longer tolerate him, and his wife considered divorce, or at least steps to prevent his returning home.

Three years later he did return home. In tattered, dirty, clothes, he announced himself to his family as a "notorious fifth columnist bringing about the end of the world." As soon as he was alone in the house, he made a suicidal attempt with gas. He was found unconscious on the floor and arrangements for admission to a Veterans Administration hospital were made.

On admission he was an untidy, malnourished, shabbily-dressed individual who talked obscenely. He was confused, hallucinating, depressed and retarded. Severe pyorrhea alveolaris necessitated the extraction of his few remaining teeth. Electrocardiograms showed evidence of myocardial damage, which contraindicated shock treatments for his depression.

While a patient at that hospital L. was first difficult to manage because of his depression and suicidal preoccupation and, later, because of almost constantly disturbed behavior which required prolonged sedative packs each day. There was a time when it appeared he was improving and he had a trial visit home, but immediately attacked his wife with an ice pick and was returned to the hospital.

At the end of four years he was transferred to Winter Veterans Administration Hospital, Topeka, Kan. On his arrival there he informed the examining physician: "I am the Prophet of the Bible. I am on earth to give life, power and strength. I must live, for only if I live can the world live." He believed that he was the chosen son of God, with this mission to perform. Frequently he engaged in odd posturing and gesticulation, with his face turned upward, carrying on conversations with someone not seen by others. He no longer was the apathetic person he had been before but was keenly aware of everything in sight, hearing or touch, and he explored each stimulus to determine its every possible implication. Usually he ascribed exaggerated unrealistic personal connotations to each.

His suspiciousness and evasiveness increased the difficulty in obtaining a detailed picture of his mental status. However, much could be learned by listening to the schizophrenic scattering stirred by almost any question. For instance, when asked, "Who is President of the United States?" he replied, "You want the real answer? There is no President. Truman. And Andrew Mellon was Treasurer before they put that woman in to steal gold from me." After any such stimulus it was impossible to stop him from a loud and prolonged harangue about how the world is controlled and of what it is made.

He professed to believe that the world consisted of a system of triangles, a "greater" triangle (land, sea and air) and some "lesser" triangles (microbes, birds, minerals, animals and plants). He believed that the greater triangle controlled the world but that he alone was in direct control of this triangle. He believed that his control of the world was enhanced by the fact that all the minerals of the world came only from his body, and that he could govern many people by holding them within his body or releasing them from his body at will. The minerals of the world consisted of gold, uranium, and "crystal white." These were, respectively, his feces,

urine and saliva. His gold made him the most wealthy man on earth, his urine made him the most powerful, and his saliva could kill microbes which otherwise destroyed people. He thought that he could convey special powers, strength, and health to others by touching them with his body excreta.

Apparently these beliefs served some usefulness in maintaining an equilibrium for him; but, on the other hand, they created a new problem, that of holding control over the world from his enemies. He feared that enemies might steal his gold and uranium and become rich and powerful, that microbes might break through his defense and destroy him, and that women or birds might read his mind and spread the secrets of his powers. It was with these fearful possibilities that he was preoccupied.

These preoccupations determined the great majority of his daily activities. He refused to use toilets because he feared enemies could tap the pipe lines underground and become rich and powerful. He accumulated his feces in his pockets, hid them away, or ate them. He urinated on radiators where the urine would evaporate, or outdoors where it would be absorbed into the earth. He went about spitting on things to free them of "microbes." He repeatedly touched people with his feces to "give them life and power," or he forced small gifts of this "gold" upon them. When he was prevented from carrying his feces, he substituted a small rag soaked in feces, urine, and saliva, crumpled tightly in his fist. All day he went about touching people with this rag.

When he left the ward, he wiped his bed, mattress, and all his possessions with the rag to safeguard them until his return. Before he touched a door knob, he wiped it with the rag. He was careful not to think his "special thoughts" around women or birds so these thoughts could not be read and conveyed to his enemies. To protect himself against poison in his food, he had a peculiar manner of holding his tray before him so that God might remove the poison. At the same time, he carried on peculiar conversations and gesticulations.

It was chiefly the possession of his feces which determined the patient's emotions. If he had possession of them, he was elated, circulating about the ward, singing, helping others and touching people in a jovial manner. If it appeared he might lose possession, he flew into a violent rage and paced the floor with violent outbursts, threats, and obscenities. If his feces were taken from

him, he was depressed and sat by himself in a corner, mute, rigid, and staring into space.

He refused to engage in any of the usual activities or to associate with other patients, declaring that all these actions were "too menial" for one of his importance. He usually refused to see people when they came to visit him, but if he did see them he endeavored to dominate and insult them, and he threatened them with violence if they claimed to be related to him. For this reason, he had been years without visitors.

The patient did not appear to be one of the best candidates for successful treatment with lobotomy. His age and the duration of his illness, his alcoholic history, evidence of vascular changes, and the absence of anyone willing to help him adjust outside the hospital were factors unfavorable for lobotomy. However his remarkable ability to organize his florid psychotic material into an integrated delusional system, his ability to fit his everyday experiences into this system, and his appropriate emotional responses to his impressions of events were favorable signs. His extreme discomfort, his periods of rage and depression, and the concomitant possibilities of homicide and suicide made it imperative that something be done; and lobotomy appeared to be the treatment of choice, even if for nothing more than symptomatic relief.

Treatment and Progress

A lobotomy was performed under general anesthesia by the classical approach, making a posterior cut involving only the medial fibers. The patient regained consciousness eight hours postoperatively and recognized familiar faces immediately. Quickly he resumed all his preoperative habits and rituals, but not with his preoperative determination. When he discovered his loss of sphincter control, he became momentarily violent with rage, tore open the oxygen tent and put his excreta in his mouth. As he started to discuss one of his "scientific" theories the following day, it was evident that much of the old spark of imagination was gone. Finding himself in a tangle of details, he dropped the subject in bewilderment. His extreme aggressiveness was gone, and his relatives were astonished to find that they could visit him without being attacked.

The immediate plan in the postoperative therapy was to help the patient establish a feeling that he was among friends and that

he was an important part of his environment. Everyone who was to come in contact with him was to take part in his therapy. His relatives were encouraged to come for short visits each day, which they did. As they found they could visit without disagreeable developments they became enthusiastic about their visits and optimistic about the future. Each day they brought new gifts for the patient. Before each visit, the therapist met with them to advise them what they might expect and how to deal with it.

During the patient's confusion and passive compliance which followed in the wake of the operation, it was possible to engage him in occupational therapy and in assisting the nurses and aides with minor chores or errands. These people encouraged him to work with them and honestly appreciated his feeble efforts to cooperate. The peculiar habits and rituals which continued to interfere with his performances were disregarded.

On the seventeenth day after the operation he stopped all activities temporarily and sat by himself on the sun porch to listen to the talking birds. "Listen! I can hear them now. They say 'There he is! He has been boiled down into a very tiny infant, placed back into a woman's womb, passed from womb to womb, and expelled right down there. We will have to feed him while he grows up because he has fed us in the past.'" He said that microbes were getting into his fingers from working with leather in the occupational therapy shop, that women were passing about his secrets as they obtained them from the birds, and that people were stealing his gold. In complete detail, he expounded his theories about the world, its structure and its control.

This was not interpreted as a will to maintain the old delusional system. It was evident that his attitude toward his relationship to the rest of the world was changing, even though his ideas about the world itself had not changed. Whereas he had had a difficult struggle in the past and was always giving, he now felt he was receiving. No comment was made as he expressed these feelings, and no change was made in his schedule of activities. New bifocal glasses and a complete set of artificial dentures were made for him. These he now gratefully accepted whereas in the past he had refused any such "bribes" or symbols of "mortality."

Daily interviews with the patient were at first informal affairs of short duration. Conversation was limited to pleasant experiences of his life, and mention of his delusions was avoided. This

was difficult for a time but gradually he began to feel that the therapist was interested in the "little" things he had done, and he began to tell more about them. As he did so, he took new interest in his present activities and discussed these too. At his request, the interviews were lengthened, and eventually the schedule was changed to one hour, four times weekly. During this time he spent hours relating the details of how he had been president of his labor organization, of how he had donated many hours of his time to the supervision of the construction of a display for his company, and of how he had toured a portion of the country with this display.

The patient grew increasingly appreciative of the attentions he was getting. He expressed his thanks for the time spent with him and he praised his new teeth and glasses, and the manner in which his meals were served. Sometimes he showed some recognition of the ambivalent feelings which had been an important factor in his discomfort. This was expressed in such statements as, "I can recall how I used to cuss you [the therapist] out plenty when I was over on the other ward. I don't know why I did it, it just seemed to make me feel better; but you know, in another way I felt worse too." He also stated, "My mother did a lot for me that I didn't appreciate, but it seems I always thought I had something valuable and she was trying to take it away from me. I never knew what a job a woman really has in having children and keeping them clean."

The relatives, to whom he had previously denied relationship, came to be referred to as "foster" or "adopted." A short time later, he admitted their relationship without reservation. He avoided commenting on this change in feeling or on any of his major delusional ideas. However, he did show a desire to talk about some relatively minor misconceptions, such as whether his eye had actually melted and run down his throat when a doctor had administered eyedrops to him. There were many similar ideas which he said he had "believed, but still didn't quite believe either." With the help of a few very simple explanations or an occasional reassuring comment he came to believe them less. His desire to discuss a great number of such fears and confused ideas became so overwhelming for him that it was necessary to see him daily for two-hour periods during the next couple of months.

In the rapid course of events which followed, it was interesting to note that symptoms were dissolved in reverse order to that in which they had developed. By the end of his treatment, he had gone through the major problems of his megalomania, narcissistic self-love, erotomania, feelings of hate and of love for fellow-men, and finally his belief that it was his wife, not he, who had had "immoral" sexual interests. It was the idea of his wife's infidelity, the first delusion that had appeared, 30 years before, which was the last and most difficult to dispel.

By the end of three months the patient was beginning to make many new friends with his cheerful and helpful attitude. He felt at ease with patients and hospital personnel, and he engaged enthusiastically in occupational therapy, the bridge club, the discussion club, the gymnasium class, dancing class, reading hour, movies, a daily visit to the post exchange, and prescribed chores. Utilizing his ability as a carpenter, he helped design and construct a new occupational therapy shop in a vacant section of the building. During this new era of security he abandoned his preoccupation with his feces, quit carrying his excreta-soaked rag, and stopped touching people. However, if frustrations occurred, or if he felt he was being excessively "babied" or "guarded," some of the regressed behavior would again occur temporarily.

His first pass from the hospital was given at the end of the fourth month. Surprisingly, the request came from the relatives rather than the patient. He saw his four grandchildren for the first time, and spent almost the entire day entertaining them. Adult relatives "complained" at the end of the day that he had not paid an equal share of attention to them, and that he was extremely careful of the time, that he not overstay his leave.

The next week-end pass was not so successful. He visited his wife and became enraged when he found a comfortably furnished home and a small amount of savings in the bank. He asserted that his wife would have to be "making money on the side by immoral practices to be able to live this way with prices as they are," and he set out to question delivery men, a son-in-law, and other suspects. He was ordered by his wife to leave the house; and he returned a day early from his pass, seeking to discuss the problem with the therapist.

He did not ask to leave the hospital again for several weeks. Before each interview he was waiting outside the therapist's door

at least 15 minutes ahead of the scheduled time. During interviews, he shouted loudly, clenched his fists and pounded them on the desk. In most respects he resembled himself as a pre-lobotomy patient.

An attempt was made not to react to his excitement or rage, but to show recognition of his discomfort, and respect for his difficult problems. However, when he charged that he was in the hospital because his wife had requested it so that she could carry on with other men, or charged that there was a plot to remove him from his rightful position as head of the house, he was told bluntly that he looked like a pretty sick fellow who might need to stay in the hospital an awfully long time. This kind of remark would have been ill advised at one time, because it would have set off a violent rage reaction with regressed behavior. Even at this time, there was some apprehension as to whether he had adequate ability to deal with such a problem or might react as before.

The apprehension faded as he stopped short, reflected seriously, and instead of continuing his efforts to maintain his beliefs, turned to asking what the therapist thought about them. He did not show any overt readiness to change his way of thinking; but, with his less dogmatic approach, he did begin to recognize some weak spots. He apologized for his difficult behavior and it was felt that a new degree of confidence had been established in the relationship.

Cautiously, so as not to expose himself to painful criticism or judgment, during interviews of the following weeks, he showed an increasing inclination to work on his problems concerning gold, uranium, microbes, electricity, abdominal organs, males and females, and women and birds who might read his mind. As the problems unfolded it was seen how each delusional idea had its genesis in his early life experiences with people, his impressions from the Bible, or his studies in elementary science. It was clearly seen how the idea that gold came from his body had its root in the demands upon him, early in life, to produce bowel movements regularly. His fantasied mission on earth and his relationship to God were almost identical with the story of a certain Biblical character of the Old Testament, in whom the patient had a special interest early in life for reasons which will not be divulged lest the patient's identity be revealed. His pathological fear of microbes grew from his having learned early that human life was controlled by electrical charges in the body cells. Since microbes carry an

electrical charge, he came to fear that contact with one might set off an electrical discharge which would leave him depleted of power. His fear that women might read his mind was based upon feelings of guilt concerning his amorous feelings toward his wife's sister and his impression that his sexual pleasures with one were shared by the other.

Frequently, the patient concluded his discussion on a given subject with a statement such as "I had some kind of a crazy idea about that which I don't need to discuss any more," or "I think I understand that now so it shouldn't bother me."

Near the end of the sixth month, this phase of treatment ended. At that time the patient asked to visit his wife, and she consented to see him once again. After his return to the hospital, his wife called to say that she thought he was wonderful and that she hoped he could soon come home to stay. He remained in the hospital three more weeks and was seen in daily interviews which sometimes covered three hours. In these interviews, in his behavior in the hospital, and in the reports of conduct on week-end passes only very minor signs of mental pathology could be found. He still kept a careful eye on his wife's activities, but his behavior no longer made an uncomfortable situation, as before. He was allowed a 90-day trial visit six months after the lobotomy.

Each week during his trial visit he returned for an interview. He was proud to report that he had found employment, and his wife reported happily that his jealousy was decreasing. He never again mentioned any delusional material; and only once did he ever show recognition of his former symptoms. This was in response to questioning at a staff conference during one of his return visits to the hospital. At that time he said his symptoms were all "water under the bridge now, and I'd rather forget about them."

During his visits to the hospital, he collected the art work he had done while he had been ill and retouched it, as by putting trees and flowers on a peculiar painting of a gold road running through barren brown hills. A friend who had known nothing of the nature of his illness reported having heard him say to some children who were playing with assorted shapes of wooden blocks, "Don't let those triangles fool you, kids. You might think you can put two of these small right triangles together and they'll make a big one, but they don't. See, they make a square instead."

Psychological tests repeated at this time showed no trace of his previous thought-disorder. Those who interpreted the results could find nothing to indicate that the patient is, or ever was, a man in need of psychiatric help. This was in tremendous contrast to the test findings before lobotomy and those of three months after lobotomy.

Relatives were still seen frequently by the therapist and social worker. At the time of planning for the patient's discharge, one of his children expressed a fear that the patient might be just acting well to get his release and would then revert to his old ways. Therefore, it was arranged that all close relatives come to the hospital that they might express their feelings as a group. It was found that this fear was not possessed by the majority of the relatives and that those who did have such fears easily realized that such a convincing job of acting would hardly be possible. Assured that the patient was actually well, everyone was able to continue warmly receptive to his return home.

Exactly nine months after lobotomy, the patient was discharged as cured. Now, three years since this dramatic change began, he is working in partnership with another man in cabinet making and doing satisfactory work. He is ambitious, neat, and friendly, and he has extended his interests, beyond merely attending to his own welfare, to making an effort to repay his wife for her long years of hard work in raising the children by herself, and to helping his two younger children through college. He is grateful to society for having tolerated him and for having given him the opportunity to "learn more in the last eight years than in the 42 before." L. has had no therapy in the past two years, but still drops in when he visits Topeka to give his personal greetings to the therapist.

Discussion and Summary

The case presented here illustrates a paranoid psychosis with many features closely resembling Freud's report of the Schreber case. No attempt will be made here to explain this patient's illness, since nothing more than a repetition of the words of Freud and others could be accomplished. The unique feature of this case is the recovery, and an effort to account for this is in order.

Without lobotomy, this patient's mental condition would in all probability be unchanged today. Without the intensive therapy

he received after lobotomy, he would have probably remained delusional and confined to the hospital, whatever the effects of lobotomy might have been.

Lobotomy diminished the aggressive outbursts which had made it impossible to maintain contact with the patient. It became possible for the therapist to establish a more helpful relationship with the patient, and for the relatives to visit with him and show their friendship and interest, rather than their fear. The vicious cycle of the patient's fear of rejection, his aggressive and domineering behavior, and the resulting fear and rejection by other people was broken. Possibly a change in the patient's reactions to id derivatives or to the direction of his super-ego, or both, account in part for his ability to deal more effectively with his problems and to re-establish ego boundaries.

It must not be overlooked that even in the course of his illness the patient was searching desperately for a means of maintaining equilibrium in the face of overwhelming psychological odds. This drive itself, backed by the intelligence and strength which had been evident during his whole life, was undoubtedly essential to the success of the treatment. The disorders of perception, the delusional ideation, and the ritualistic behavior are, to be sure, grave indications of severe pathology; but, nevertheless, within these same phenomena of restitution, lies evidence of the struggle against submission.

The lobotomy and the therapy which followed were planned to provide the patient with an experience of re-birth and a new experience of growth and learning, this time in an environment controlled to suit his particular and changing needs. From the psychological standpoint, the experience of awakening after lobotomy might for several reasons give an impression of re-birth. The temporarily altered state of consciousness, loss of sphincter control, change in emotional tone and intellectual processes immediately following lobotomy might be very much like starting life anew, and might bring about a change in the individual's conception of himself, of the world about him and of the relationship between himself and the world. After lobotomy, then, it should be important to exploit this opportunity in therapy, giving the patient every possible reason for optimism about his new impressions before the routine course of events returns him to the old.

It may have been a fortunate circumstance that this patient did interpret the experience in exactly this way, as he so lucidly expressed it on the seventeenth postoperative day. From the time of his "re-birth" until his readjustment outside the hospital the course of his "growth" and learning followed symbolically the course of normal human development.

The plan of postoperative therapy was co-ordinated with this "growth" process. First his feeding and personal hygiene were closely attended to by others, he was given special articles of comfort and enjoyment, and numerous relatives came to see him daily. He received dentures, and his diet was changed accordingly. As he learned to trust and confide in one person who permitted him to progress at his own rate and for a time placed no particular demands upon him, he began to orient himself in relation to that person and later in relation to other people. Using the therapist as a base of operations, the patient entered into activities within the hospital and was able to call upon the therapist for help when he encountered the realistic demands of life. During the process of emancipation, he extended his activities beyond the hospital boundaries, retreating to the therapist and the hospital for help when he ran into a problem. Eventually he had solved most of the problems in his relations with other people and was able to maintain himself in society with confidence and without need of his pathological defense mechanisms or need of the hospital for support. He then extended his interests even beyond gratification of his own immediate needs and set out to help others.

The patient's relatives deserve a large share of credit for the final outcome. Frank,[2] in an intensive and extensive study of the effects of lobotomy in psychotic patients, has found that schizophrenics who have nobody to accept them after operation cannot make an adjustment outside the hospital. He points out the importance of a supporting and accepting relationship with others if a schizophrenic patient is to get well, and that if conscious or unconscious hostility prevails in the relatives, such a rejection seals the fate of the patient. Other persons who were essential to the patient's recovery were Dr. John Kooiker, the ward physician, who was always sensitive to the patient's changing needs; Miss Jean Thorpe, the ward nurse; and the various occupational therapists and aides who helped create the kind of atmosphere in which the patient could re-establish his self-confidence.

This man remains well without further support because he has "found" himself in relation to other people. Emotional tension has been relieved as a result of his new self-confidence and of the permanent tension-relieving effects of lobotomy, so that there has been no return of such mental discomfort as would necessitate his resorting to pathological mechanisms for relief.

Menninger Foundation School of Psychiatry
Topeka, Kan.

REFERENCES

1. Freud, S.: Psychoanalytic Notes on an Autobiographical Account of a Case of Paranoia. (Dementia Paranoides). Collected Papers, III. Hogarth. London. 1925.
2. Frank, Jan: Some aspects of prefrontal lobotomy under psychoanalytic scrutiny. Psychiatry, 13:35-42, February 1950.

THE NEUROSES OF EVERYDAY LIVING*

BY DAVID C. WILSON, M. D.

Ecology is the name given to that branch of biology which deals with the relation of the organism to its environment. Medicine in the past has had the tendency to look on man as an animal and to carry over into the study of man those things learned from the study of other animals. Human physiology has been the most important subject studied in our medical schools and this science has been based to a large degree on the animal reactions of man. Man is undoubtedly an animal, but also an animal that has built up an artificial environment with which he has interacted for ages. Man's personality is to a large extent the product of this interaction. Therefore, the writer predicts that human ecology will soon have as important a place in medical teaching as physiology does today. The study presented here could be considered as an exercise in human ecology: the relation of man to his environment.

The dichotomy of mind and body has disturbed thinkers over the centuries. The concept of the personality as a whole was created to combat this dichotomy and to emphasize the unity of all human behavior. This idea of oneness has been carried along by the term psychosomatic, which, in a paradoxical way, again emphasizes the dichotomy of mind and body because the word is so constructed that it intimates that psyche and soma are separate entities. Recently, investigators in the fields of psychology, sociology, and psychiatry have returned to the concept of the person as a whole as an object for study. They emphasize the unity of his behavior and emphasize that the dichotomies rest in the eye of the beholder. It is the different points of view that make the difference between psyche and soma. The difference depends on the field of reference, not on any innate character of the human being himself.

If you wish to approach the subject from the point of view of physics you follow the laws of physics. If you wish to apply biochemical tests, you use biochemical formulas. When the study is made of the behavior of the person as a whole, you apply the laws of psychology. When you are considering this total behavior in

*Address at the bimonthly conference of the New York State Department of Mental Hygiene at Albany, March 27, 1952. Co-publication by arrangement with *The Virginia Medical Monthly*, Richmond, Va.

the terms of the individual person, your study is psychological; but you use the laws of sociology when you study the actions of groups of individuals. At all times, it is important to remain in one's field of reference, so that confusion will not arise from applying laws which hold in one area to another where they do not necessarily apply.

The idea of the integration of the whole personality brings this out quite clearly. There is the subatomic level, the atomic, the molecular, the anatomical, then the biological, and finally, the total individual. Yet the individual is again a part, when we realize that he is part of a community and is influenced by pressures from without as well as from within. Each level of integration can be considered discretely, only if considered in a special field of reference, since each, while a whole from one point of view, is always a part of a greater whole. It is important in the study of the stomach to know what kind of a person it is in, just as it is important to know what kind of a community a person lives in to understand that person. In studying the stomach, we apply the laws of physiology; when we study the kind of person the stomach is in, we apply laws of psychology. If we study the influence of the community, we apply sociology when we approach from the community standpoint, but psychology, if from the standpoint of the individual. The person as a whole, therefore, while an individual unit, is under the influence of his parts and is at all times acting as a part in a larger whole.

The study reported here is of the behavior of the individual as a whole when he acts as a part of a group, or at least when he responds to the pressures of his culture. The field of reference is at all times that of the total individual. The effects of culture-pressure on the delinquent and on those definitely mentally ill have been reported frequently; but this study differs, in that it attempts to show how exaggerations, which are considered normal, may cause distortions which have injurious effects on the normal individual. There seems to be a tendency of humans to exaggerate. If some of anything is good, then more is better, and so on, until the exaggeration becomes painful. These injurious exaggerations trap individuals to their hurt so that they act in a manner which is, for them, unreasonable. The writer has called this resulting irrational behavior the neurosis of everyday living.

The term, neurosis, is applied to behavior which is irrational to a sufficient degree to disturb the individual in his relations to other individuals and to behavior which the individual may recognize as irrational but of which he does not know the cause. A neurosis is distinguished from a psychosis by the fact that a neurosis is irrational under a definite set of circumstances, while a psychosis is behavior which is irrational under all circumstances.

The influence of the general culture on the individual is well known. The impact, on the individuals concerned, of specific pressures within the culture has usually been considered for its intrapsychic implications and not from the points of view of the general characteristics of the behavior of the persons under the specific pressures. When a juvenile delinquent is studied, the effects of the impact of culture are presented in great detail as far as the structure of that delinquent's behavior is concerned. Also the effects of war, the crime movies and the comics on the same delinquents are frequently investigated, but there is very little consideration given to what culture pressures, drives, obsessions are doing to normal everyday people who make up our world. The behavior of these people is more important than that of those who are definitely sick. We shall now consider the interaction of these everyday people to a few of the trends in American culture.

This year is especially outstanding because of the presidential election. One group of voters will be vying against another to win. Most of the voters of the country will consider themselves Democrats or Republicans. They will do as the party of their choice instructs them and they will feel the way they consider Republicans or Democrats should feel. They will become members of groups which control their lives and determine their destinies. The analysis of why a person joins one party and not another would lead far afield. Indeed, it would be necessary to study the details of each individual's life to determine the reasons for joining and being carried along in any particular mass movement.

There are many group activities similar to political party behavior which influence the lives of everyday Americans. Sometimes the group influence works out for the good of the individual involved and sometimes both the individual and the community are injured. Disturbances of health and happiness, which may lead to gross behavior disorders in both the individual and the group, often follow.

Sociologists and social psychologists have been studying the characteristics of groups and group activity. They have reached several conclusions regarding the nature of group behavior. According to Kreck and Crutchfield in *The Theory and Problems of Social Psychology,* a group does not mean a collection of individuals characterized by some similar property. Thus, for example, a collection of Republicans or farmers or Negroes, is not a group but a class of people. The term, group, refers to two or more people who bear an explicit psychological relationship to one another. A collection of Republicans working together to win an election becomes a group. A farmers' co-operative is a group. The various members exist for each other in some significant way. The criterion for recognizing a group is whether the behavior of other members in the supposed group has any direct influence on the behavior of the given individual and whether his behavior has direct effect on the other members. Such influence may be slight and vague. It is psychological, not material, but is definite enough to be recognizable.

A person, a community, a state or national organization, can act in a manner so distorted and so full of danger that the action must be considered diseased, even though no one seems aware of the diseased state. Football as a sport, for instance, has many values both for those who play and for those who watch; yet, of late, the game with all that goes with it has become a monster which menaces the integrity of our youth and distorts to an alarming degree the behavior of our colleges and universities. The behavior of some religious sects amounts to masochistic orgies when self-sacrifice and suffering are exaggerated to an extreme degree. Labor unions have done much for the working man, yet they, in turn, may evidence abnormal behavior which is a menace to the nation. It may be concluded, the writer believes, that, just as individuals behave at one time in a normal fashion and at another in an abnormal manner, so groups may evidence well-balanced behavior at one time, yet at another show most unusual and bizarre conduct.

To the individual caught up in such a mass movement, nothing seems to be wrong. This individual attitude of innocence makes it worth while to study the situation of the individual caught up in a group which has ceased to act in a normal manner. Mass behavior of any sort is composed of individual behavior of a similar nature, which is as badly diseased as the group action is diseased.

If we observe this individual, however, he shows no signs of suffering. He is not thought to be abnormal by his fellows, or by those who are not caught up in the mass movement. He is not suspected of either neurosis or psychosis.

Individual neuroses and psychoses are forms of behavior which arise from within the person and are developed on an individual basis. While a person sick with a neurotic reaction may be a member of a group, and while his neurosis may lead him to aid in the group distortion, yet, at heart, he is antisocial, since he wishes to control others by his own methods for his own ends. His reaction is one that cannot be shared with anyone else. He is a person who attempts to solve life's problems in his own individual way by his own techniques. These techniques are often exaggerated to such a degree that they irritate the group. The group shuns, excludes, ostracizes, and often attacks, this individual who dares too much individuality.

The actions of these individuals—of the person suffering from an individual neurosis and of the person taking part in a group distortion—have many similarities. First, in each, there is an exaggeration of a form of behavior beyond the limits of what, to the clear-thinking individual, seems warranted by the circumstances. In the individual neurotic, the pain or the paralysis cannot be explained by anatomical structure or by reasonable disease. In the group distortion, the best interests of the individual are obviously sacrificed beyond the demands of rational needs. Second, both forms of behavior injure interpersonal relations. In the long run, each tends to make more difficult the ability of people to live together. This trend may lead to infringement on the laws of the land, to the impoverishment of people, or to actual conflicts—within individuals, between individuals, or between groups of individuals. The first type of behavior, when the law is broken, is called criminal. The second, where people are impoverished materially or spiritually, is often disguised as public welfare or deficit spending. The third form of neurotic behavior, arising from conflict, may be made manifest in symptoms, such as headaches, on the individual level; as race or religious prejudice on the community level; and as war on the international level.

The similarity of individual neurotic behavior and neurotic behavior produced by group pressure is that the cause of the excess is not known to the performer of the action. The neurotic head-

ache is said to come from a bad tooth, but the real cause is hatred of a mother-in-law. The prejudice against the Jew is said to be because the Jew has all the money in the world, while the real reason is the group's own insecurity—and perhaps a need to escape from feelings of self-hate. The cause for war is often said to be for the sake of democracy, while the actual cause is the lack of self-confidence which produces fear, and the hate fear engenders.

Finally, causes for this exaggeration common to individuals and to groups of individuals may be understood by both the individual and the mass; yet neither the individual nor the group is able to modify the irritating behavior sufficiently to end the irritation. This fact represents a resistance to change resulting from the long period of training which produces the abnormal behavior, and from the many secondary gains which accumulate, as the creation of the reaction is effected. War offers a very good illustration of this situation. The causes of war are well understood: Everyone agrees that war as a technique for solving man's hostility to man is outmoded, yet we live under a constant threat of this form of group psychosis.

The neurosis of the individual caught up in a group exaggeration, and the neurosis which is entirely a result of the individual's own efforts to get along in life, have many differences as well as similarities. One of the outstanding differences is that the perpetrator of group action has no idea that he is sick, nor is he considered to be odd by anyone in his social setting. In fact, he may be looked upon as an example of correct behavior. He may win medals and be promoted by members of the group to places of leadership. The adoration of the group often calls for the senseless selection of such a hero for a position for which he is in no way qualified. Also, persons not entangled in the group distortion consider the behavior of individuals involved to be acceptable. What is more unreasonable than a mass of rabid individuals of late middle age rushing pell mell over the highways, where death lurks at every turn, just to be in on the "kick-off"? Few would consider these persons neurotic even when they sit out on concrete seats in a blizzard, while other men whom they hardly know and can scarcely see, run up and down a frozen field assaulting one another. The causes for this abnormal exaggeration of behavior are also behind the force that makes some college presidents perjure themselves for the sake of winning football teams. No one consid-

ers such a president's action proper, although it is condoned, while the actions of middle-aged alumni are not questioned. Indeed, the abnormalities of behavior of individuals carried along by groups are so common to everyday living that it is difficult to designate the point at which the disorder becomes a disease. This depends, the writer believes, not so much on the behavior of the group but on the significance of the behavior to the individual concerned. Therefore, this condition is not a neurosis of the group, but one of individuals, and our field of reference is still the person as a whole who acts as a part.

A definition that would cover the idea embraced in the discussion just given can now be developed. A neurosis of everyday living occurs when socially-accepted behavior is exaggerated to such a degree that it interferes in an injurious manner with interpersonal relations, and the performer is unaware of the actual cause for his behavior, or—if he becomes aware—is unable to modify the exaggeration. In contradistinction to a person with an individual neurosis, the persons showing the reaction do not consider themselves sick. They are not considered sick by the others in the group or by the bystanders who observe their behavior.

The attitude of a large number of individuals toward the game of football represents this form of neurosis. The behavior of many Americans at Christmas offers another example. "Keeping up with the Joneses" represents another exaggeration that disturbs comfortable living. The influence of labor unions and of big business on interpersonal relations is worthy of study. The mass hysteria on New Year's Eve is an example of a variation in the same disease. Deficit spending could be considered a neurosis of everyday living at the national level. This unreasonable behavior probably developed as an exaggeration because of the long training given to citizens of this country in buying on the installment plan. When the citizens of Virginia are referred to as Democrats, that is a classification. When they elect a candidate, that is normal group behavior. But when citizens as Democrats allow a self-perpetuating organization to control their destinies over a generation in spite of the fact that this organization often acts contrary to their wishes, then they as individuals are suffering from a neurosis of everyday living. War represents the example of an international exaggeration of socially-accepted group hostility which is called nationalism. There are many such distortions which af-

fect the lives of us all. Country club life may destroy some individuals. The idea fostered by many merchants that society demands a yearly crop of debutantes is a racket for some, and a neurosis for others. How can one expect to end the abnormal relations between the colored people and the white as long as many of our churches draw the color line? Understanding the causes and effects of such behavior does not help many individuals who are swept along in the group. They must be able to act on their knowledge. They must divorce themselves from the area of pressure.

Recently a middle-aged man came into the psychiatric clinic of the University of Virginia Hospital. He complained that his right arm was paralyzed. The arm hung in a limp fashion. Apparently he could not move it. Also, when the arm was examined further it was found to be anesthetic to pin prick. Sharp instruments could be driven through the skin while the patient sat smiling. He declared he could not feel any pain. All examinations of the arm failed to show any defect. The blood flow was normal, the nerve supply was normal. Reflex activity was normal. The man was cured rapidly. He left the clinic with a normal arm but he was not quite so happy. In the course of clinic work with him, it had developed that he hated his wife. She had demanded that he cut wood. His paralyzed arm had enabled him to frustrate her demands. He had unconsciously separated his arm from the rest of his personality so that no will power of his could make it move or feel. In the case of the individual this is known as a hysterical reaction. The arm is said to be blocked off, or excluded, from the rest of the person. The cause in this case was the hatred and fear of the wife and the determination to frustrate her wishes. There was perhaps, also, a dislike of wood chopping!

In 1865, a constitutional amendment made the colored man a citizen of the United States. The southern states were forced to ratify this amendment. There were many feelings of hatred and hostility toward their recent deadly enemies who now demanded that their former slaves be recognized as their political and social equals. The acceptance of the role demanded was too much, and a hysterical sort of blocking off, known as segregation, came into existence. By means of this reaction, the white citizen was able to exclude the colored man from his life. The colored man didn't exist. He was put in special places that could be ignored. He

could not come out of these areas unless he assumed a role of servility or appeasement which might be called the "Uncle Tom" reaction.

Segregation became a fixed pattern of behavior, probably initiated because of the hostilities engendered by the War Between the States and by the stupidity of those in charge of the reconstruction period. The colored man of that day was illiterate and dependent. He was totally unprepared for citizenship or for a position of social equality. Segregation was a method of defense created by the white man to thwart a hated order and to help solve an intolerable situation. Segregation was accepted by the colored man as an escape from many situations that were embarrassing to him. The similarity of the hysterical blocking off of an arm and the excluding of colored people must be apparent to everyone. Segregation could be called a form of neurosis of everyday living. People of the south are caught up in this reaction and carried along regardless of their own reasons for acting the part assigned to them. Certainly they could not be called sick because they act out their roles. Yet by doing so, they are perpetuating a form of behavior which is contrary to the fundamental principles of our democracy.

Segregation is like individual neuroses in many ways. The debacle of 1861-1870 may have precipitated the disease, but its roots lie in the distant past. The reason for its present existence is found in outmoded ideas of one sort or another and to secondary gains that accrue to certain individuals, thus making it worth while to sustain the reaction. As in all other forms of group neurosis, each individual has his own reasons for joining the movement. In one case it is ignorance; in another, fear; in another, insecurity; and in another, a shrewd awareness that segregation reduces competition, thus making more jobs available to less efficient people. To others, segregation gives, or preserves, a false pride based on feelings of unwarranted superiority.

A certain amount of race prejudice can be considered normal; but when it develops to such a degree as is manifested toward the colored people in the United States, it interferes with interpersonal relations and so becomes a neurosis of everyday living. The treatment of this disorder can be attempted by individuals, but group therapy would be much more effective.

The best attack would be on the causes which are grounded in race prejudice. The emphasis should be on democracy and the assault on the false concept that the American is always a Protestant Anglo-Saxon. Although there are many kinds of people, there is only one type of citizen and that is a first-class citizen. In the army, race prejudice was often forgotten, because men worked together for a serious cause. Groups devoted to a cause would have no place for prejudice. The ability of persons to get along with each other depends to a large extent on their ability to identify. Their ability to relate depends on their ability to accept the qualities of one another. Their relatedness, therefore, depends on the possibility of their knowing each other as individuals, so that they can find acceptable qualities which will permit identification. It is impossible to identify with a stranger; but if that stranger has value in promoting a common cause, the strangeness disappears, and identification is possible. The church with its group activities, and the mental hygiene societies—since they must deal with minority groups—are excellent organizations to undertake the therapy of this disorder.

There is another form of segregation existing in our midst. The reaction of the individual is similar to that just described. It is a blocking off similar to that seen in hysteria. The reaction the writer wishes to discuss is that of the person who considers himself normal toward all those who are labelled as having mental disease. We might call this "the great segregation."

As soon as the patient begins to show symptoms that are out of line, he begins to be excluded. This is true in the family when the existence of the mental distortion becomes a family disgrace to be hidden—a skeleton in the closet. In the community, this same reaction occurs, but it is most marked in a general hospital, especially if there is a psychiatric ward attached to it. As soon as any patient becomes disturbed on a general ward, he must be transferred to psychiatry forthwith. There is an attempt to exclude the psychiatric ward from the rest of the hospital and to consider the psychiatric staff as separate from the rest of the medical school. It has been only recently that medical schools have begun to consider mental illness as a type of human disease. The medical profession at large still does not consider the mentally sick as its responsibility. A patient came to the University of Virginia Hospital psychiatric service the other day because of back pain of

20 years duration. She had had four operations on her back and three on her abdomen. The note on the chart by the referring doctor stated that he thought they should operate again, but that, if that didn't work, he was "afraid" they would have to call in a psychiatrist. This patient had presented a definite psychoneurotic reaction since childhood. The medical refusal to consider an evident neurosis is a variant of this blocking off reaction ("the great segregation"), where the disease is blocked off but not the patient. If the doctor accepted the disease as a neurosis, he would have to block off the patient lest he become contaminated because he treated such disorders. He would be afraid that he would "lose face" in the community.

The schizophrenic feels the community hostility, so weaves it into his fantasy. He takes advantage of the desire to isolate what is queer to get what he wants—isolation. Thus the ostracism of the mentally ill aids and abets the development of many psychotic reactions.

The reaction toward the mentally disordered has all the characteristics of a neurosis of everyday living. It is an attitude that upsets interpersonal relations in a tremendous fashion. It prevents the proper care of those thought to be sick and heightens the fear and prejudice of those who think themselves well. The person taking part in the segregation is often not aware that he suffers from an exaggeration; and, if he is aware, cannot modify his attitude. Finally, he is not considered abnormal by any of his group.

Not only do the persons caught up in this exaggeration exclude the mentally ill in "the great segregation," but their reaction is so great that they also exclude the hospitals for the mentally ill, their staffs and, frequently, the very existence of mental illness. We know now that people who are mentally ill can never be well until they have learned to get along in the community without the use of their illnesses. Therefore, a return to the community is as important to all of the mentally ill as it is to those maladjusted individuals called alcoholics. It is essential that we as psychiatrists, for the good of our patients, recognize and attack this neurosis of everyday living, the hysteroid exclusion of the problems connected with mental illness. We can apply to this larger field what has been learned in the handling of those whose common symptom is the inability to handle alcohol—the value of group therapy. The

way to break down the individual attitude is to organize groups which understand and no longer fear the mentally ill. The community must go to the hospital, but groups in the community must also accept the mentally ill sufficiently to identify to such an extent that they cease to have prejudice, fear and a need to ostracize.

If we understand these reactions of everyday life, not as mass movements, but as examples of individual behavior in response to culture pressures, then the psychiatrist can remain in his field of reference which is that of treating the personality as a whole. Such an understanding will facilitate clear thinking and permit application to these "caught-up" individuals of those techniques used successfully in the treatment of other forms of distorted human behavior.

Department of Neurology and Psychiatry
University of Virginia Hospital
Charlottesville, Va.

METHODS IN GRAPHOLOGIC DIAGNOSTICS*

BY WLADIMIR ELIASBERG, M. D., Ph.D., F. A. P. A.

I

Graphologic diagnostics is part of the science of the expressions. The history of the lore of the expressive movements through the centuries, may be summed up in the following antithesis. On the one hand, expression was explained away and dissolved, as it were, in an anatomy of the muscles and a physiology of the muscular movement. On the other hand, scientists and sages have risen time and again to defend the independence of expression, denying that the birthright of expression could be sold for a mess of bones and sinews. This antithesis contains the description of two groups of methods that are basic in graphologic diagnostics, to which should be added a third group, the group of the statistical methods.

If one omits the older, more or less erratic, approaches that are mentioned in most textbooks of graphology anyway, what may be called the science of graphology originated in 1875 with Michon's *Système de Graphologie*. This book fully deserves the adjective "scientific" because the method applied is no longer some sort of vague intuition, but is systematic induction. Apparently the one and only basis, though, for all the author's far-reaching statements is the statistical evaluation of the combination of certain optomotoric signs with certain well-known character traits and personalities. It is known, e. g., that Victor Hugo, was a poet with much imagination. So his handwriting has to give away this character trait, and so on. Finally the character of a person to be analyzed is built up like a jigsaw puzzle. It is quite clear that, though inductive, this type of characterological graphology could not amount to much because it neglected the fact that a human person is a dynamic whole. Indeed this method has never been applied consistently, to the exclusion of other viewpoints.

Nor did inquiry proceed along these lines, although the graphology of the signs has followers to this day. The next steps were taken by physiologists, neurologists, in short, by medical men.

*Reference is made here to an article of 1944, see bibliography. W. Eliasberg, No. 4. The term "graphology" has been fraught with all sorts of exaggerated claims and hostile prejudices. It should be replaced for scientific purposes, and the writer suggests that "graphologic diagnostics" be used instead. The word "graphology" is still being made use of here, however, particularly where there are historical reasons.

It was a decisive step ahead in this field when, in 1895, Preyer, a professor of physiology, neglecting the forms of single letters, searched the general properties of human movements and found their vestiges in the straight line, in the point, in the obtuse, acute and right angles, and in the curves. Preyer tried to show that all differences in the handwriting rest finally upon variations of the slanting, the length, the width of the stroke, the continuity, and the connections. He also devised a system to take account of such disorders of handwriting as might be caused through disease. Etiologically, he thought, anomalies of the brain cortex might be involved, together with centripetal, sensory disorders.

Goldscheider not only enlarged our knowledge of the sensory, kinesthetic controls, but also introduced an experimental method to get pressure graphs, and, in this way, developed important facts. Speedy handwriting, he found, yields higher spikes on the pressure graph. At the same time, the average level is higher; and it never reaches the zero line, which may be the case in slow writing. These facts, together with more regularity of pressure in speed, might explain the well-known fact that graphologists prefer to analyze speedy writing and think slow writing amenable to falsification.

Erlenmeyer discussed two important disorders, the atactic, and tremor writing. What he described, is not, however, the atactic, in the neurological sense of that word, where it connotes a disorder referable to the sensory pathway. His description refers to severe malformation of the letters, slipping of the stylus, increase of pressure, loss of round forms.

The psychiatrists, Meyer and Lomer, forged ahead on the pathway of the analysis of handwriting. Meyer was one of the first to examine samples of manic-depressives in order to establish the expression of certain typical emotions in the handwriting. Thus the method of pathography was introduced into the field at a time when the psychology of normality, too, was prepared to study significant pathological cases. In graphologic study, as in psychology, the method has proved fruitful, but dangerous.

Analyzing both writing and designing of the psychotic, Rogues de Fursac described, in the act of writing: first full conscious and purposive muscular contractions, which are destined to move the pen, to design the form, and to exert the necessary pressure on

the paper. He described, second: automatic contractions that are almost reflexive and entirely unconscious. These result in the fixing of the hand and the forearm and in the counterbalance of the effect of gravity. Says Rogues de Fursac: "If the voluntary and conscious movements are diminished, but the automatic contraction preserved in full energy, then the hand, while producing the correct forms, will not exert sufficient pressure on the pen point; the writing will be thinner than normal." This is the case in melancholic writing, where the trouble is essentially in the conscious and voluntary movements, with no true muscular paresis. If the motor function becomes weakened in its totality, then the reflex manifestations weaken, together with the voluntary movement. The hand is no longer kept up against gravity; it will, through its own weight, weigh down the pen point; and an abnormal pressure will betray itself in pastiness. The handwriting becomes smeary, as is the case in writing during the re-evolution after the epileptic fit.

On the basis of modern insights into the structure and functions of the brain stem and the big nerve nuclei, Rudolph Pophal, a German professor of neurology, who has become a full-fledged, in fact a full-time, graphologist, has offered valuable insights into what he calls the types of handwriting of the striatum and the pallidum, as compared with the traits stemming from the cortex. Without going into detail, one can see that this is an elaboration, on the basis of the new brain physiology, of the clinical teachings of Rogues de Fursac.

Pophal also examined, in a very interesting way, the physiology and psychology of rigidity and stiffness in handwriting—which is in no way identical with pressure. He differentiates between true rhythmical pressure and pseudo-pressure which is not rhythmical on the one hand, and the degree of stiffness on the other; some degree of stiffness, i. e., of posture, is, of course, necessary in any handwriting. More insight could be gained by studying action currents of the muscles, a method that is not difficult to apply, but as far as the writer knows, has not been consistently used in graphological experiments.

One may now turn to the methods on which a respectable number of publications in England, France, Germany, and the United States have been based. Critical surveys have been made by Allport and Vernon, and by K. Buehler. Allport and Vernon's pub-

lication also contains a criticism of the somewhat wanton reviewers of graphological publications. Nobody will deny that graphologic science has to be experimental, or it will not be a science at all. But here the ways part: There is an *a-prioristic* way, which would define in advance what the aim should be, and what method should be devised and there is, on the other hand, a truly experimental way of devising methods. Here the experimental object stands in the middle of the deliberations. Some typical statistical experiments of the older type were used by Michon and Saudek; and there were, from the beginning, physiological experiments by Goldscheider, as have been described. In the United States the matching experiments have been favored. They have, however, often been done with little thoroughness on both the psychological and graphological levels.

Matching experiments usually have been devised to measure the reliability of the judges, not, directly, the validity of the prediction. (Gerald R. Pascal's experiments, for example, had only the reliability of the graphologist in mind.) It will be pointed out later, in discussion of the combination methods, that the so-called reliability experiments are of much less importance than the validation that can be gained only through combination. Obviously, it does not mean any too much for organized graphologic study, if somebody who claims to be a graphologist is found to be falling short of his claims.

To the validation experiment, one would also add the clinical psychiatric observation already mentioned. Also usable for validation purposes are the facts which we know about change of handwriting under the influence of moods, temperament, acute emotions, alcohol, fatigue, disease, change of job, life crises, hypnosis, imitation, admiration and adulation.

In the writer's own publication on "political graphology" (W. Eliasberg, No. 3), it was shown that there was a certain type of script indulged in, in the inner circle of the German National Socialists, including Hitler. This is the German, highly angular script, the Bismarckian handwriting. While this is the expression of will power (of which more later) there is a second type of handwriting, that of Hindenberg, which is absolutely devoid of any signs of outstanding character, intelligence or will power. As this man was washed to the crest, his handwriting, too, had great

influence, which the author has shown in tracing the development of Hitler's signature.

The signature of Joseph Goebbels in 1928 was an average round Latin script. In 1934, as *Reichspropagandaminister,* Goebbels wrote the angular upright German script of the inner circle. It cannot, of course, be said to what degree such changes were brought about consciously and intentionally. Nor is it necessary to know this. Witting or unwitting, the change itself is one of the most important facts in what the writer would like to call Developmental Graphology. If one understands fully the idea of developmental graphology, he must always try to obtain comparative material, both for research and for giving opinions. For research purposes, children's handwritings will be compared to those of adolescents and adults, in an attempt to find certain constants. The research worker will follow changes in the pressure, configuration, and other characteristics in pre-puberty and puberty. In preparing an opinion, he will request material of both former years and of the present time. In forensic cases especially, developmental viewpoints will enable one to establish the identity of the writer or writers of one or more documents better than heretofore.*

In the preceding paragraphs, there has been reference to methods oriented upon the interpretation of the expressions in handwriting. Indeed, the separation of the three groups of methods just discussed, is an abstract one. In any concrete graphological investigation or opinion, measurements, statistics, physiological experiments and interpretations should be combined, if at all possible. There are other combinations which will be discussed later.

The question to which one must now turn is that of the right and title of the expressive methods. Any graphologist will appeal to intuitions for the symbolic meaning of movements and their vestiges. The problem, however, is: Can it be proved that graphology's basic assumptions of the non-neutrality** of the space and the non-neutrality of the directions of the movements are correct? If such assumptions be correct, it should be feasible to prove them

*For instance: Interesting applications of developmental graphology have been made by Erich Feuchtwanger and K. Roman-Goldzieher. In certain cases the handwriting reached a higher level of form (*Formniveau*) parallel to a higher level, after lesion to the brain, of the whole personality.

**Pulver, Max: Symbolik der Handschrift.

in the production of non-script material such as doodlings and scribblings, too—in material which is to script as senseless syllables in psychological experiments are to words and sentences.

Such material indeed exists in the modern psychodiagnostic and projective experiments. The writer has culled at random two of them, one by a psychiatrist, well versed in experimental psychology, the other by a psychologist, who worked in a psychological laboratory. I refer to E. Mira's "Myokinetic Psychodiagnosis" and to Johanna Krout's "Symbol Elaboration Test." Mira found that in general the length of movements tended throughout to decrease in inhibited subjects and to increase in excited subjects, irrespective of the content of the question or the nature of the verbal reply.* (Mira, p. 135.) "In anxiety states and in excited or elated patients," says Mira, "there is a tendency to accelerate the movements and to increase the length of the lines, whereas in the states of inhibition, depression and amazement a retardation of the movements leading even to complete cessation may be observed." On the basis of these experiments, Mira is in a position to differentiate between egofugal and egopetal movements. The tendency to abduction is called increase of the vital space. The alteration of the relationship between the ego and the world reveals itself best, as Mira finds, in the sagittal plane of the movements. He also finds a difference between the movements of the two hands in that the movements of the right hand are more related to the present personality and character and those of the left hand to constitutional trends and temperament.** A great number of other statements gained from scribblings in the myokinetic experiments are apt to confirm basic assumptions of graphologic diagnostics.†

Johanna Krout's "symbol elaboration test" consists of the following: A number of semicircles, straight lines, crossing lines, semicircles combined with straight lines, jagged lines and the inverted V pattern, are offered for drawing completion. The complete picture is discussed with the subject and it is found that indeed there is a universal symbolism of straight lines, semicircles, diffuse masses, the jagged line, and so on. The jagged-line pat-

*This and the following give complete confirmation of the graphological findings in manic-depressive patients by Lomer, Meyer, Heinen, and Rogues de Fursac.

**Ross, Nancy Wilson: The Left Hand is the Dreamer. William Sloane. New York.

†For interesting material gained from a scribbling chimpanzee, see Paul H. Schiller.

tern—which, incidentally was the symbol of the most aggressive units in Hitler's army—is interpreted by Krout's subjects as symbolic of war, aggression, etc. The rounded lines were those of femaleness, femininity; straight lines and, especially, crossing straight lines, were connected with aggressive moods, like the jagged line. Krout was able to compare her results with those of other investigators, e. g., Immerglueck and Cohen (unpublished) and found them confirmed.

Krout does not refer to a previous German publication by E. Wartegg which appeared in 1939, *Charakter und Gestaltung.* Similar patterns were offered for completion, and Wartegg makes the statement that the results of his tests bear out comparison with graphological investigation. One might also think, in this respect, of older attempts to compare the handwriting of creative artists with their work. This latter method has, however, been used almost exclusively by people given to mere intuitions (*Schau*) and no results of scientific value have become known to this author. As a result, then, of these experimental investigations about symbolism in handwriting, one can say: *Investigations which were not done for graphological purposes are likely to bear out the assumptions of graphologic study; and, at any rate, possibilities for further experimental investigations are offered.*

Instead of going into a rebuttal-criticism of certain critics of graphologic diagnostics, who think it is the latest fashion to proclaim quantification as the only principle of science (cf.: Cooper and the writer's refutation in "Methods in Graphology"), the writer prefers to continue with the survey of the methods that have yielded positive results. It has already been stated that confrontation of methods yields better results than the obsessive, lopsided application of only one method. In other words, the writer does not believe in one central graphological method or test. Each method may become central, according to the problem. In one case of identification, ultraviolet spectroscopy might be decisive, in another one the investigation of symbolism. However, each of the methods should reflect the problem in the way the sun is reflected in a dew droplet.

The Germans, who have been furthering the study in various ways, may also be credited with having established the necessary connections between graphologic and other methods. (Pauli, R., and Hager, W.) Here also may be cited some former papers of

the present author which appeared in the years of 1923-1930. (Eliasberg, W.: summed up in Nos. 1 and 2.)

Pauli had the subjects work with the Kraepelin calculus columns (*Rechenhefte*). The material was evaluated in various ways: (1) by direct observation by the examiner of the subject at work; (2) by unconscious expressive movements of the subject, particularly satiation, disgust, fatigue, desire to leave the field, annoyance, second wind, etc.; (3) by conscious introspection of the subject; (4) by the objective graph showing the various changes in the number of examples solved as a function of time; (5) by the quality of work; and (6) by the graphological interpretation of the numbers* as specimens of handwriting.

The last, indeed, being an entirely new field of inquiry, the psychologist proceeded in an extremely cautious way; he showed the differential expressive "charges" of the single numbers and sum total. He was able to use this material the way graphologists use ordinary samples.

As to character diagnosis on the basis of the work experiment, Pauli and his co-workers have also proceeded cautiously. Each one of the factors that appear in the graph: speed (number of problems solved), speed-increase with training; decrease connected with various factors such as fatigue, satiation; speed with which the peak is reached; length of the plateau time, etc., need interpretation. There is no point-to-point relationship between a specific trait and a quantitative element of the graph, rather—just as in characterological graphology—interpretation of the work graph must be done on the basis of the general level of form of the work.

It has already been mentioned that the graphologist, whenever possible, should think of checking the various methods against each other. Interview methods, work tests, projective tests, should be applied whenever possible. "Graphology in distress," which so far has been the normal situation, should not be considered the desirable one.

II

In sending material—of which specimens are produced here (Figures 1 to 6)—for a graphological opinion, a client pointed out that he was interested in the following questions, "provided they

*Numbers are as readily amenable to graphological interpretation as scribbling (see foregoing).

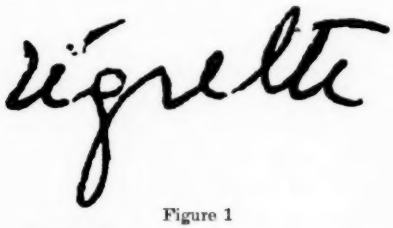


Figure 1

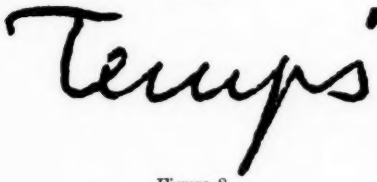


Figure 2

Figure 3

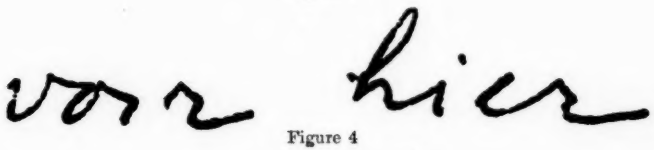


Figure 4

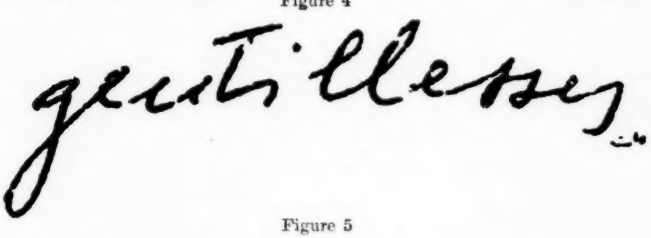


Figure 5

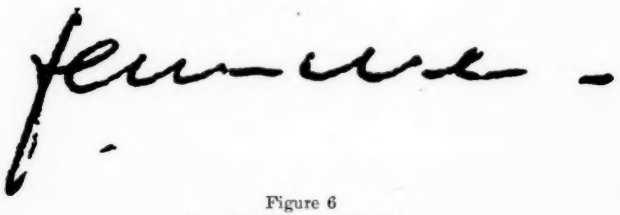


Figure 6
All pictures are enlarged 1:2.

fall into the realm of analysis of handwriting": "1. Degree of intelligence of that man and his capacity to grasp and understand —analytically—complicated situations. I mean, of course, complicated business situations but I suppose that as far as intelligence rating in general is concerned, no such difference can be made in analysis. 2. Is this gentleman usually given to expressing his mind openly or does he use his language to hide his thoughts? 3. Is he usually persevering and energetic or is the contrary the case? 4. Has he the ability to arrive independently at decisions and if he has made up his own mind, does he go through with a decision which he has taken? 5. Has he the ability and the will to lead others in a course on which he has set out?"

The sample consists of a letter, six and one-half by five and one-half inches; the space on which the writer has written is about five by five inches; the paper is a somewhat heavier type than is ordinary; there are 14 lines, written with a ball-point pen.

For the evaluation of the specimen, none of the physiological or projective methods mentioned in the foregoing could be used, because the person, who had produced the specimen, was absent and could no longer be reached.

Further objections have to be discussed in advance. First, the fact that the script was produced with a ball-point pen creates difficulties in our present state of knowledge. Persons who routinely request handwriting analyses such as heads of personnel bureaus, etc., should therefore ask for fountain-pen specimens. The enlargement of the photostatic copy shows numberless interruptions in the single letters, abrupt changes of pressure, and so on. In a specimen produced with the usual fountain pen or pen point, this would point almost certainly to a severe neurological disorder. Produced with a ball point, these interruptions are of no consequence; on the other hand, the enlargement is sufficient to differentiate genuine changes in pressure from such differences as those caused by the unequal flow in the ball-point. At any rate, pressure differences in this particular sample should be handled with reserve and attention.

A second factor is that the writer of the letter is obviously not too familiar with the French language, in which he writes. There are several misspellings which would not occur in the case of a born Frenchman of his degree of education. Should a specimen in a not absolutely familiar language be used for the diagnosis?

While the present author mentions this objection, he does not feel it is very important in this particular case. French and Italian, while different languages, obviously have similarities in the nature of the general motoric attitude in handwriting. And there is indeed, no motoric trouble visible which would be due to the non-familiarity with the language. On the contrary, if a man who does not write his mother tongue, produces such a round and fluent specimen, the assumption is warranted that the psychomotoric process of writing is, all the more, characteristic of the writer.

Having made these objections and having pointed out the lack of checks, the writer wants to say that the following description of the motoric type and its characterological interpretation can be made with that reasonable degree of certainty which is necessary in any scientific diagnosis or opinion. In other words, it is the author's conviction that this opinion can be given with the necessary degree of reliability and validity.*

Analysis of the present specimen:

Motoric characteristics: This handwriting shows a slight slanting to the right, with very few changes in the degree of slanting.

The words are well spaced, which gives the whole letter a certain rhythm. The lines occasionally show a slight tendency to climb at the right end. There is, however, a very slight tendency to fall at the end of single words; and certain letters that are usually not handled as underlength letters, as the "s" at the end of a word, are written with underlength extension.

As to *alignment* within the word, there are occasional curves as in "*avoir*"; in "*gentillesses*" (Fig. 5), the base forms an arch with an upward convexity.

Connectedness: A complete connectedness is visible in the words "*temps*" and "*vous*"; but, on the whole, most words show no complete connectedness. There is usually a break—that is generally not caused by an upper sign, as the accent sign, *grave*, etc.

Type of connection: The type of connection as visible, e. g., "*temps*" and many other words trends toward the garland, although the type is not very distinct in this respect, but there are no arcades and very few angles.

*"Reliability is the accuracy with which a measuring device measures what is measured. [It is] the consistency between results or repeated administration of the same measuring device to the same individuals. Validity is measured by the correlation of the variable with a criterion." (Dorothy C. Adkins.)

The writer would suggest instead that reliability be called the degree of agreement and conformity among various judges; validity, the direct prediction value of the test: i. e., the constancy of repeated test results, also their correlation with other (criterion) tests.

There is, however, a slight tendency for the connection type to assume the form of the so-called thread which is most pronounced in the first "m" of "*femme.*"

On the whole, then, if one imitates the movements of this writing with the hand, there is a feeling that the connection type is one of softness, tenderness, gentleness, sympathy and warmth. And with this, omitting further details of the motoric picture, the writer comes to the interpretation.

The character of this man can be best conceived from his emotional life. As was said before, he is a sympathetic, a friendly person; he likes good relationships with people; and the writer wants to say—answering here also Question No. 2 as to whether he is usually given to expressing his mind openly: He certainly is. There are no signs whatsoever that would point to a habitual reserve, to a tendency toward hiding, let alone lying.*

A person with these characteristics, if living in the surroundings of business life, can, however, not help incurring obstacles, resistances, competition, enmity. What are the general characteristics of this man, if he is exposed to such "stimuli," which are normal in business life?

As long as possible, he will try to avoid open fights—and maybe even a little longer, he will try to keep up friendly personal relationships.

He is definitely not a fighter. And he is not compelled by his inner tendencies to get to the top of the pyramid. On the contrary: His inner tendencies are best served by what might be called "*superior subalternity*" (cf. Eliasberg: ***Rechtspfliege und Psychologie,*** p. 661). His inner tendency, then, is rather to learn than to lead, to take orders rather than to give them. His intelligence, however, is good, although not analytical. He has a good intuitive grasp but he will not choose analysis as his first method. This type of intelligence explains why the writer thinks that he qualifies best for "superior subalternity" (*Gehobener Unterbeamter*).

What will happen, if this man is put in a place where subalternity just won't do? If, e. g., as the son of a superior father he inherits a big business and has to lead? He will be unhappy and will long for a place near to the top rather than "on top."

The handwriting is suggestive of difficulties having weighed him down already, e. g., the thread in "femme" and some other motoric irregularities (slanting) which were mentioned before.

While one cannot, in this paper, go into the details of the problems of leadership and administrative ability and the expression thereof, this much is clear: Before giving a graphological diagnosis as to the presence of character traits that are favorable or unfavorable for the development of such qualities, a job analysis of the leader (cf. Bernard, Chester I.; Lepawsky, Albert, and

*Signs of reserve or lying: Pulver, and Saudek No. 2.

Simon, H. A.), and the administrator in general, and an analysis of the requirements on the particular job must be done. This problem will be taken up in more detail in a forthcoming paper on the handwriting of the administrator and the political leader. Suffice it to say that such a comparison is especially fruitful, if one can demonstrate pertinent changes in the development of a personality accompanied by parallel changes in handwriting. Material for this is indeed available; see the forthcoming paper.

Aftermath

The following facts were ascertained within half a year after giving the foregoing opinion. The client's first impression from business intercourse with the subject had been in keeping with the general trend of the opinion. The client had felt that his interlocutor was a smooth, although not glib, pleasant and amiable man whose presence gave one the gratifying feeling of unquestionable superiority.

The client's wife, while dancing, said: "You do not feel you are led by a male, he is like cotton." His outward appearance is like that of a Russian student in the 80's in Zürich. Approaching his fortieth year, he is somewhat shortsighted, has a long nose, has rather long hair, wears dark-rimmed glasses, but is on the whole an interesting and good-looking fellow.

The client's idea had been that, with the absence of signs of ruse, deceptiveness, etc., a compact with this subject would work out nicely, although he was astonished that, in the negotiations, the man gave in on practically every point. Occasionally he himself and his co-workers thought that they might be dealing with an exceptionally wily person who might be seeing some hidden advantages.

From the beginning there were difficulties. Finally the client went abroad in person to look into the matter; and what he found out was this: The subject, the scion of a very prominent and wealthy industrial family, was the younger son of a dominant father and had been pushed aside by his older brother and forced to subordinate himself. The two senior partners of the firm were indeed very wily and resourceful persons; they had sent the younger brother to make a deal without ever intending to carry it out. In the family council, the younger brother was constantly cornered, not only by the two men, but also by his own wife, who,

10 years younger than he, is a very beautiful, energetic, intelligent and domineering person.

Looking back to these experiences, the client said: "It was my fault that I read only half of what was said in the opinion. I was impressed with the lack of deceptive tendencies, but I did not pay sufficient attention to the subaltern type of motivation. I have learned my lesson; and, in the future, if I am told that the negotiator, although personally an honest man, shows signs of 'subalternity,' I shall not deal with him at all, I shall try to do my dealing with those really in power, not with the one who comes into my office brandishing a power of attorney."

The author's opinion came very close to a "complicated social-psychological reality." How was this achieved? Not by any intuition (*Schau*) or mystical divination. It was through the combination of social-psychological experience—especially in the administrative process and in the way of reaching decisions among a small group of industrial leaders—with graphological methods and, of course, the insights of the psychiatrist and psychoanalyst into emotional dynamics, that has allowed such empathy: not telepathy, but empathy based on methodological approach and experience.

420 West End Avenue
New York 24, N. Y.

BIBLIOGRAPHY

Adkins, Dorothy C.: Construction and Analysis of Achievement Tests. 1947.

Allport, G. W., and Vernon, P. E.: Studies in Expressive Movement. Macmillan. New York. 1933.

Barnard, C.: The Functions of the Executive. Harvard University Press. 1948.

Binet, A.: Les Revelations de l'écriture. Alcan. Paris. 1906.

Buehler, K.: Die Krise der Psychologie. G. Fischer. Jena. 1927.

Cooper, J. B.: A comment on graphology. J. Psychol., 17:263-267, 1944.

Eliasberg, W.: 1. Von der Vernunft bis zur Rationalisierung (from reason to rationalization). J. A. Barth. 1932.

2. Rechtspflege und Psychologie. Carl Heymann Verl. Berlin. 1933.
3. Political Graphology. J. Psychol., 16:177-201, 1943.
4. Methods in graphology. J. Psychol., 18:125-130, 1944.
5. Graphology and medicine. J. N. M. D., 100:4, 1944.
6. Forensic Psychology. Southern Calif. Law Rev., XIX:4, 1946.
7. New light on contested wills. J. Crim. Law and Criminol., 39:5, 1949.

Erlenmeyer, F. A.: Die Schrift Grundzuege ihrer Physiologie und Pathologie. Bonn. Stuttgart. 1879.

Feuchtwanger, E., and Goldzieher, R.: Handschriftuntersuchungen an Hirnveletzten, Veraenderungen der Schrift durch umschriebene Hirnfunktionsstoerungen. Schweizer Archiv. f. Neurol. u. Psychiat., 34:1, 1934.

Fursac, Rogues de: Les écrits et les Dessins dans les Maladies Nerveuses et Mentales. Mason. Paris. 1905.

Goldscheider, A. J. K.: Zur Physiologie und Pathologie der Handschrift. Arch. f. Psychiat., 24:509 ff., 1892.

Heinen, M.: Die Handschrift der Manisch Depressiven. Thesis. Bonn. 1938.

Krout, J: Symbol Elaboration Test. Psychological Monogr., A. M. A., 64:4, 1950.

Lepansky, A.: Administration. A. A. Knopf. New York. 1949.

Lomer, G.: Ein Fall von zirkulaerer Psychose graphologisch gewürdigt. Ztschr. f. Neurol. u. Psychiat., 1930.

Michon, J. H.: Methode pratique de graphologie. Payot. Paris. 1949.

Meyer, G.: Die wissenschaftlichen Grundlagen der Graphologie. Gustav Fischer. Jena. 1901.

Mira, E.: Psychiatry in War. Norton. New York. 1943.

Pascal, G. R.: 1. The analysis of handwriting; a test of significance. Charac. and Personal., XII:2, 1943.

2. Handwriting pressure: Its measurement and significance. Charac. and Personal., XI:3, March 1943.

3. Review of Werner Wolff's: Diagrams of the Unconscious. J. Abnor. and Soc. Psychol., 44:3, 428 ff., 1944.

Pauli, R.: Arbeitsversuch als charakterologisches Pruefverfahren. Ztschr. f. angewandte Psychologie und Charakterkunde, 65:1 and 2. Joh. A. Barth. Leipzig. 1943.

Pauli, R., and Hager, W.: Arbeitsversuch und Graphologie. Ztschr. f. angewandte Psychologie und Charakterkunde, 65:5 and 6. Joh. A. Barth. Leipzig. 1943.

Pophal, R.: 1. Die Handschrift als Gehirnschrift. Der Geifenverl. zu Rudolfstadt, 1949.

2. Zur Psychophysiologie der Spannungserscheinungen in her Handschrift. Greifenverl. zu Rudolfstadt, 1949.

Pulver, M.: Symbolik der Handschrift. Orell Fuessli Verl. Zurich. 1931.

Remplein, H.: Arbeitskurve; Beitraege zur Typologie und Symptomatologie der Arbeitskurve. Beih. z. Zeitschr. f. angewandte Psychologie, 91, 1942.

Resten, R.: 1. écritures et Malades. Librairie Le François. Paris. 1947.

2. Les écritures Pathologiques. Librairie Le François. 1949.

Roman-Goldzieher, K.: Studies on the variability of handwriting. J. Genet. Psychol., 1936.

Saudek, R.: 1. Experiments with Handwriting. London. 1928.

2. The Psychology of Handwriting. London. 1936.

Schiller, P. H.: Figural preferences in the drawings of a chimpanzee. J. Compar. and Physiol. Psychol., 44:2, April 1951.

Simon, H. A.: Administrative Behavior. Macmillan. New York. 1948.

Stern, W.: Die differentielle Psychologie. Joh. A. Barth. Leipzig. 1911.

Wartegg, E.: Charakter und Gestaltung. Beih. d. Zeitschr. f. angewandte Psychologie. 1939.

Wolff, W.: Diagrams of the Unconscious. Grune & Stratton. New York. 1948.

Wormser, Peter: Die Beurteilung der Handschrift in der Psychiatrie. Rascher Verlag. Zürich. 1947.

EVALUATION OF TREATMENT AND RELATED PROCEDURES IN 1,216 CASES REFERRED TO A MENTAL HYGIENE CLINIC*

BY SOL L. GARFIELD, Ph.D., AND MAX KURZ, M. A.

The purpose of the present study was to analyze the results of treatment and related problems in the Veterans Administration Mental Hygiene Clinic, Milwaukee, Wis. At the time the data for this study were collected (May 1950), the clinic had been functioning for over three and one-half years, and no comprehensive appraisal of its procedures and activities had ever been made. Prior to a more intensive evaluation of therapeutic procedures, it was deemed worth while to make a general over-all appraisal of certain factors related to treatment. These included such matters as length of treatment, sources of referral, types of cases, termination of treatment and available evidence on the results of treatment. While material of this type is of primary importance to the clinic being evaluated, it is also of general value to other clinics. Those clinics which have made somewhat comparable studies[1, 2, 3, 4, 5, 6] may find the present investigation of special interest. In addition, the present findings may stimulate others to plan research pertaining to their own therapeutic programs and also may emphasize problems which are common to most clinics.

The Milwaukee Mental Hygiene Clinic

Some description of the clinic setting is important in evaluating the results. The Milwaukee Mental Hygiene Clinic was established in August 1946 to provide out-patient diagnosis and treatment for veterans with service-connected neuropsychiatric disabilities. The clinic thus served adult veterans from the entire state of Wisconsin. At a later date, another clinic was established in Madison to serve more efficiently veterans in parts of the state remote from Milwaukee. The data in the present study, however, are based only on cases seen at the Milwaukee clinic.

The number of staff personnel, as well as the patient load, has fluctuated. When the clinic first opened, the professional staff consisted of one full-time psychiatrist, a half-time psychiatrist

*Reviewed in the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

and one social worker. At its peak in June 1949, the clinic staff included three psychiatrists, three clinical psychologists and three social workers, augmented by 11 part-time or attending psychiatrists. At that time, the case load consisted of 256 active cases with 516 treatments given during that month.

Patients are referred to the clinic from a variety of sources. Slightly over half of the cases were referred from the V. A. Medical Out-Patient Clinic and approximately one-quarter were referred from the Vocational Rehabilitation and Education Division. The remaining cases came from other sources with about 11 per cent referred from non-V. A. agencies.

Cases usually are seen initially by a social worker. After the social history is obtained, the veteran is seen by a psychiatrist for an intake examination. Since 1948, when psychologists were added to the staff, an appointment for psychological studies has been scheduled if the veteran is considered to be a potential treatment case or in need of additional diagnostic study. Up until the spring of 1950, the clinic also provided services three evenings a week. Since that time, the evening hours have been discontinued.

It is difficult to categorize the clinic further, since the personnel has changed considerably during the time it has been in operation. The change in full-time psychiatric staff has been most marked, while there has been minimal turnover among the social workers. Without question, the clinic reflects the policies and proficiencies of the staff at a particular time. It is difficult, therefore, to generalize about it *per se*. Nevertheless, an appraisal of its activities over a period of several years should contain some findings of general significance.

The Present Study

In order to obtain a better understanding of activities in the clinic, a survey was made of all closed cases in the clinic files as of May 1, 1950. After a preliminary investigation of a sample of case files, certain methodological procedures were instituted. For the purposes of this study, only those patients were to be included who actually came to the clinic and were interviewed by psychiatrists. Twelve hundred and sixteen cases met this criterion and constitute the sample for this investigation.

The case records in the clinic files were the sources of information. The quality and quantity of information provided in these

files was extremely variable. Some of the material was exceedingly brief and incomplete. Whenever possible, needed additional information or verification was obtained from other official records. To increase objectivity, any ambiguous material was evaluated by both authors. Furthermore, no attempt was made by the present investigators to evaluate treatment since the material in many of the case files was so limited. The therapists' evaluations were accepted at face value for purposes of tabulation.

A few additional points should be clarified here. The patient's first interview with the psychiatrist was always considered part of the intake process. Subsequent interviews with the psychiatrist or other therapists were classified as treatment interviews. If the patient was offered treatment but was not interested in accepting it, he was listed as refusing treatment. Likewise, if the patient received an appointment for a treatment interview but failed to keep it or return to the clinic, he was considered as refusing treatment. However, if the veteran discontinued coming to the clinic after one or more treatment interviews, he was listed as breaking off treatment. Some such categorization had to be set up and followed to decrease the subjective evaluation of the data.

Subjects

The 1,216 subjects whose files were analyzed in the present study were predominantly veterans of World War II, with 97 per cent of the group in this category; 98 per cent of the veterans were males and the median age of the total group was 28.28 years (Q=4.22). Of this entire group, 1,132 had only one sustained contact with the clinic for examination or treatment. By this, it is meant that a case was never reopened after the original contact with the clinic was terminated and the case officially closed. In contrast to this, there were 84 veterans whose cases were reopened one or more times. For the sake of clarity and convenience, most of the analyses are based on the "single contact" cases which represent 93 per cent of the total.

One can best categorize the patients by stating that the majority were diagnosed as psychoneurotic. Although each case file was carefully analyzed, it was frequently difficult to ascertain a definitive diagnosis. As might be expected, cases with long clinical histories may have had two or more diagnoses, some of which were widely disparate. Actually 27 per cent had multiple diagnoses in-

cluding both neurotic and psychotic classifications. For these reasons the following groupings based on the most recent clinic diagnoses have been used to indicate the psychiatric classification of the patients: psychoneurotic reaction, predominantly anxiety type, 63 per cent; schizophrenic reaction, 17 per cent; other psychotic reactions, 4 per cent; and other categories, including alcoholism, character disorder, epilepsy, etc., 16 per cent.

Results

The first analysis of the data concerns the disposition made of each case after the original intake procedures. Of the 1,132 "single contact" cases, 364 were seen for examination only. In these cases, no out-patient treatment was considered. In 158 of these cases, it was the psychiatrist's opinion that therapy was not indicated. It can be added that many in this group were referred by the Vocational Rehabilitation and Education Division for examination in terms of their feasibility for training. An additional 63 cases were considered as not feasible for therapy; 57 were declared ineligible; and in 69 cases, hospitalization was recommended. Thus, 32 per cent were not offered treatment for various reasons. In the Boston[1] and Los Angeles[3] V. A. clinics, approximately 22 per cent of the incoming cases were not given treatment for similar reasons, whereas, in the Madison clinic,[6] 31 per cent of the patients seen during the intake procedures were classified as "no case made." Since the administrative procedures in these clinics vary somewhat, the figures may not be directly comparable.

The remaining 768 patients were offered out-patient treatment. Of this group, 208, or 27 per cent, refused treatment, and 560 patients, or 73 per cent, accepted treatment. The comparative number of veterans refusing treatment was not so large as in another recent study.[7] It is interesting, nevertheless, to note the number of veterans who refused free psychiatric service. Additional comparisons cannot be made since this particular problem has not been specifically treated in other reports.

Length of Treatment

Length of the treatment given was the next area studied. The data are given in Table 1. As is evident there, the median length of treatment falls between six and seven interviews with approximately two-thirds of the cases receiving less than 10 inter-

views. Only seven cases received over 50 treatment interviews. These findings agree closely with those reported for other V. A.

Table 1. Length of Treatment

Number of interviews	Number of cases	Percentage of cases
Less than 5	239	42.7
5-9	134	23.9
10-14	73	13.0
15-19	41	7.3
20-24	24	4.3
25 and over	49	8.8
Total	560	100.0

mental hygiene clinics. In the Boston V. A. clinic 50 per cent of the cases were discharged within the first 10 hours of treatment[1] and in the St. Louis clinic 55 per cent of the cases received less than five treatments.[2] A similar emphasis on brief psychotherapy was also reported by Rennie[3] in a psychiatric rehabilitation clinic for veterans where the average treatment ranged from six to 12 interviews. It is interesting to note also that the number of clinic visits in four psychiatric clinics attached to general hospitals in New York City was closely comparable to the data reported here. Almost half of the treated patients in these clinics had fewer than five contacts with the clinics and 74 per cent came less than 10 times.[5] The reports on duration of treatment from two other V. A. clinics[4, 6] are given in months which, without further clarification, cannot be compared directly with the present findings. However, it can be noted that over 40 per cent of their patients had less than three-month contacts with these clinics. Undoubtedly, this time interval also reflects relatively brief contact with the patient.

The significance of the relatively brief treatment received in this and the other clinics is difficult to evaluate. Before discussing this problem, however, it is worth while to analyze how treatment was terminated. Such an analysis may be of some importance in the final analysis of the therapeutic results.

In almost two-thirds of the cases treatment was terminated by the veteran himself (See Table 2). Most frequently the patient simply failed to return for scheduled appointments. Only 18.6 per cent of the cases were terminated by the therapist in terms of actively-concluding psychotherapy, although in those cases hos-

Table 2. Termination of Therapy

Means of termination	Number of cases	Percentage of cases
Terminated by veteran	368	65.7
Terminated by therapist	104	18.6
Hospitalized	33	5.9
Declared ineligible	31	5.5
Veteran moved away	13	2.3
Others	11	1.9
Total	560	99.9

pitalized, (5.9 per cent) the decision, of course, was made by the psychiatrist. The actual reasons for treatment being stopped by the veteran are not available.

Comparable data are reported by three other V. A. clinics. In Boston, 58 per cent of the cases were closed as a consequence of failure to keep appointments,[1] whereas the Los Angeles clinic reports 31 per cent of its cases closed for similar reasons.[3] Although the Madison results are not completely clear, in at least 58 per cent of the cases, treatment was terminated by the veteran.[6] In the study of the New York City clinics already referred to, "in over half of the treated cases, the patient merely failed to keep an appointment and then never returned" (Ref. 5, p. 10). While these figures appear appallingly high, a report on 100 successive cases in private practice indicates that 40 per cent of referrals never return after the initial interviews.[9] In any event, this appears to be a problem which has received comparatively little attention and is of some importance not only from therapeutic concern in specific cases, but also in terms of the waste of time involved when an appointment is not kept. This matter will be considered again after reviewing the therapeutic results in the present study.

Evaluation of Treatment

Of the 560 patients who accepted and received some treatment in the clinic, evaluations of treatment by the therapist were lacking in exactly three-quarters of the cases.* Undoubtedly, in a large number of cases where treatment was terminated by the veteran after a few interviews, the therapist saw little need to add a

*Since this study was begun, a directive has been issued by the Veterans Administration requiring a formal summary of treatment when any case is officially terminated. At present, therefore, all cases contain a closing summary and evaluation.

formal statement concerning its outcome. In general, where therapy was terminated by the therapist, some evaluation of therapy was made and noted in the record. In less than 10 per cent of the cases where therapy was closed by failure of the veteran to continue in therapy, was an evaluation of therapy recorded.

It is thus difficult to make an adequate evaluation of therapeutic efforts. In addition to the limited data available in the case file, the lack of a reliable and uniform method of appraising therapy adds to the complexity of the problem. Not only were many different types of evaluations made, but even where the same term was used—e. g., improved—one cannot be sure if similar results were obtained. In the 103 cases terminated and evaluated by the therapist, over 25 different evaluative terms were used. The latter included such descriptive categories as: "Improved, greatly improved, slightly improved, much improved, some improvement, maximum improvement, fair adjustment, symptomatic improvement, further treatment not required, seems to have adjusted, recovered, treatment completed successfully, etc." Since these different evaluations lack precise meaning, all those signifying some improvement were grouped together. These results are listed in Table 3. To make comparisons simpler, the data are classified

Table 3. Evaluation of Treatment

	Number of cases	Number evaluated	Evaluation Improved	Evaluation Unimproved
Terminated by veteran	368	34	27	7
Terminated by therapist	104	103	81	22
Other means of termination	88	5	5	0
Total	560	142	113	29

separately in terms of how treatment was brought to a close. According to Table 3, where evaluations of therapy were recorded by the therapist, some improvement was noted in approximately four out of five instances. As indicated previously, however, such ratios of improvement are rather meaningless. In addition to the problem of the validity of the therapist's evaluation, not much is known about the therapeutic outcome in the other 75 per cent of the cases which received no evaluation. Two findings suggest that therapy was not very successful in a large proportion of those cases. These are the relative brevity of treatment, and the fact

that so many cases were terminated by the veteran's refusal to continue treatment. It is also possible that, were any noticeable improvement evident in those cases, the therapist would have been likely to record it. It is obvious that the percentages of improvement obtained from the cases where such evaluations were available are not representative of the entire clinic population.

In line with the preceding discussion, there is not much to be gained by comparing the present findings with those of other clinics. Similar criticisms can be made of most of the criteria of improvement used. For example, the percentage of cases "improved" ranges from 25 per cent[1] to 73 per cent[4] in the various reports, with most clinics reporting improvement in over half of their cases. Undoubtedly, these differences are in part a reflection of different goals and methods of evaluating psychotherapy.

Results and Length of Treatment

It is interesting, however, to comment upon the generally favorable reports of therapy in the light of the relatively brief treatment given. In only one investigation was brevity of treatment considered as minimizing therapeutic gain. In that particular study,[5] a definite relationship between length of treatment and therapeutic outcome was observed. For purposes of comparison, a similar appraisal of outcome and length of therapy in the present study is presented in Table 4. In a general way, there is a tendency for a relatively higher percentage of improvement to

Table 4. Evaluation and Length of Treatment

Evaluation	Number of interviews						
	Less than 5	5-9	10-14	15-19	20-29	30 and over	Total
Improved	34	27	18	11	11	12	113
Unimproved	10	13	2	1	1	2	29
Total	44	40	20	12	12	14	142

be associated with increased length of treatment. On the other hand, over one-half of the cases judged to be improved had less than 10 interviews, and 30 per cent of the "improved" cases had less than five interviews. However, one cannot draw reliable conclusions from these particular data, since the sample is not

fully representative of all patients treated, and the evaluations of improvement are somewhat dubious. The variability among patients and therapists must also be more clearly understood.

Discussion

What implications or conclusions can we draw from our findings and those of related studies? In the first place one can clearly perceive the importance of the patient's motivation in accepting or continuing psychotherapy. In few other areas does one find treatment rejected so frequently by those judged to require it. One can at least speculate on some of the factors responsible for this. One possible explanation is that psychiatric treatment is still viewed with some suspicion by many people and they are afraid of being considered mentally ill. This is closely related to the fact that the patient's symptoms serve important needs of the individual, and treatment is definitely a threat to his present level of adjustment. Another aspect of the problem, of particular importance with veterans, concerns the disability compensation the patient receives for his symptoms. This undoubtedly plays some role in the veteran's attitude toward treatment.

Other major findings concern the brevity of treatment and the fact that a majority of treatment contacts are broken off by the veteran. Some of the matters already mentioned apply here also. Other possible explanations might include the following: inadequate orientation to psychotherapy, unskilled handling of the case, situational stress removed, or satisfaction with limited improvement. Each of these points obviously could be elaborated upon in greater detail, but such elaboration is not necessary here. It is worth while, however, to comment upon a few findings which strike the writers as particularly significant. In regard to the brief psychotherapeutic contacts reported in this and related studies, several questions immediately come to mind. In the first place, what is the average number of treatment interviews utilized in non-V. A. adult mental hygiene clinics or in private practice? With the exception of some reports from psychoanalytic centers, there is a scarcity of adequate information on this problem. The same can be said in terms of the number of patients who terminate treatment by themselves after a few interviews. One is also interested in the relatively good results reported with very brief psychotherapy. If these reports are valid, more research should be directed toward

ascertaining more precisely the treatment methods and goals utilized in such treatment since, traditionally, psychotherapy has been viewed as a long and expensive undertaking. Psychotherapeutic techniques which insure successful outcomes in less than 10 interviews are of decided social worth.

The final topic of discussion centers around the problems of evaluating the effects of psychotherapy. There are many methodological considerations which are scarcely touched upon in the various reports on psychotherapy. As already indicated, in the absence of standard criteria of improvement, one cannot reliably compare the results of one clinic or one approach with that of another. The judgments made are subjective and reflect the view, biases and knowledge of the individuals concerned. These are reflected not only in the varying percentages of improvement mentioned in the studies reviewed, but also in the way similar phenomena are differently evaluated. For example, whereas in the present investigation and in one other study,[5] the frequency of patients who terminate therapy by failing to keep appointments is viewed as indicating unsuccessful termination, in another study over half of such cases are viewed as improved.[6]

There is little question that more rigorously defined and objectively applied criteria are necessary for a more adequate appraisal of psychotherapy. Furthermore, in all of the studies discussed in the present paper neither a control group nor a comprehensive follow-up investigation was used. Such factors must be considered in planning adequate research in this area. For intensive appraisals of psychotherapy, additional considerations should include the type of patient, the presenting problems and symptoms, the current life situation of the patient, the personality, training and approach of the therapist, the relationship developed in therapy, and the resulting changes in both the patient and his environmental situation.

Summary

The records of 1,216 cases referred to a V. A. mental hygiene clinic were analyzed for purposes of appraising treatment and related matters. Analysis of the data revealed that 32 per cent of the persons referred were not offered treatment for a variety of reasons. Of the remaining patients, 27 per cent refused to undertake treatment although it was offered to them. An analysis of those accepting treatment showed that the median length of treat-

ment fell between six and seven interviews, with approximately two-thirds of the cases receiving less than 10 interviews. In almost two-thirds of the cases, the treatment was terminated by the veteran, himself. Evaluations of treatment were provided by the therapist in only one-quarter of the cases treated. Generally, improvement was noted in over three-quarters of these cases. While there was a tendency for a relatively greater frequency of improvements to be related to length of treatment, over one-half of the cases judged to be improved received less than 10 interviews.

The foregoing results were discussed and compared with comparable findings in other studies. Particularly noted, was the rather high incidence of improvement with very brief psychotherapy. The inadequacy of current evaluative reports was discussed with particular emphasis on the ambiguity and subjectivity of existing findings. The need for more rigorous and meaningful appraisals of psychotherapy was emphasized, along with some suggestions for improving research efforts in this area.

V. A. Mental Hygiene Clinic
Milwaukee, Wis.
and
Waukesha County Guidance Clinic
Waukesha, Wis.

REFERENCES

1. Adler, M. H.; Valenstein, A. F.; and Michaels, J. J.: A mental hygiene clinic. Its organization and operation. J. N. M. D., 110:518-533, 1949.
2. Blackman, N.: Psychotherapy in a Veterans Administration mental hygiene clinic. PSYCHIAT. QUART., 22:89-102, 1948.
3. Futterman, S.; Kickner, F. J.; and Meyer, M.: First year analysis of veterans treated in a mental hygiene clinic of the Veterans Administration. Am. J. Psychiat., 104:298-305, 1947.
4. Tissenbaum, M. J., and Harter, H. M.: Survey of a mental hygiene clinic—21 months of operation. PSYCHIAT. QUART., 24:677-705, 1950.
5. The Functioning of Psychiatric Clinics in New York City. New York City Committee on Mental Hygiene of the State Charities Aid Association, New York 10, N. Y., 1949.
6. Wermuth, K. D., and Wilhelm, E. W.: An analysis of 706 cases of the Madison V. A. Mental Hygiene Clinic. M. S. Thesis, University of Wisconsin, 1950.
7. Psychiatric Needs in Rehabilitation. New York City Committee on Mental Hygiene of the State Charities Aid Association, New York 10, N. Y., 1948.
8. Rennie, T.: Psychiatric rehabilitation therapy. Am. J. Psychiat., 101:476-483, 1945.
9. Rickles, N. K.; Klein, J. J.; and Bassan, M. E.: Who goes to a psychiatrist? Am. J. Psychiat., 106:845-850, 1950.

REACTION TO STRESS IN SCHIZOPHRENIA*

BY HENRY PECHSTEIN, M. D.

In schizophrenia one sees an apparently different behavioral reaction to certain environmental stimuli from that which one would expect in a normal person. This gives the appearance of incongruity between thought processes, emotions and behavior, described by Bleuler as a fundamental symptom of the illness. A question which arises is whether this difference of reaction is purely an aspect of behavior or whether there are also alterations in the basic physiological processes of adaptation. In this respect, certain observers showed a difference in adrenocortical function as measured by changes in the lymphocyte count between psychotic and non-psychotic individuals in response to temperature extremes and also in response to fatigue.[1, 2] A regular stress reaction (drop in lymphocyte count) was seen in non-psychotic individuals, while anomalous changes were noted in schizophrenic patients in reaction to fatigue. A similar drop in lymphocytes in reaction to heat and humidity was noted in non-psychotics while a rise was seen in the patients. These workers also noted a drop in lymphocytes in normal people in the morning and a subsequent slow rise toward evening.[3] This was not noted as regularly in cases of schizophrenia.

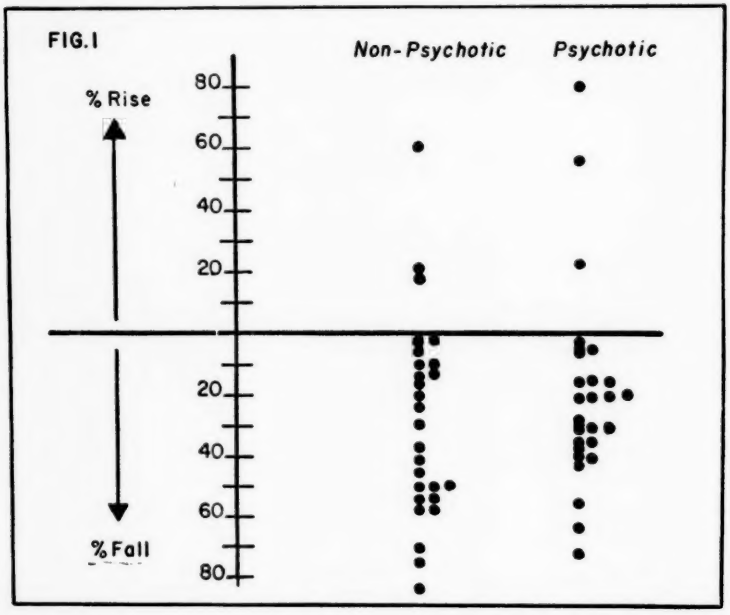
Spiers and Meyer found that in mice any handling or excitation produced a drop in circulating eosinophils similar to that following adrenalin or ACTH injection.[5] They also found the eosinopenia proportional to the amount of cortin injected in adrenalectomized mice, which indicated that the eosinopenia following stress in mice with an intact adrenal cortex could be caused by liberation of that gland's secretion.

Adrenalin was one of the substances found to cause this reaction in human subjects, Thorn, et al., noting a 50 per cent or greater drop in circulating eosinophils after subcutaneous injection of epinephrine.[5] They also pointed out that norepinephrine, which has comparatively little central nervous system stimulating power, does not have these eosinolytic properties. This suggests that the reaction to epinephrine might be via the central nervous system.

*Read at the downstate interhospital conference at the New York State Psychiatric Institute, New York, N. Y., April 11, 1951.

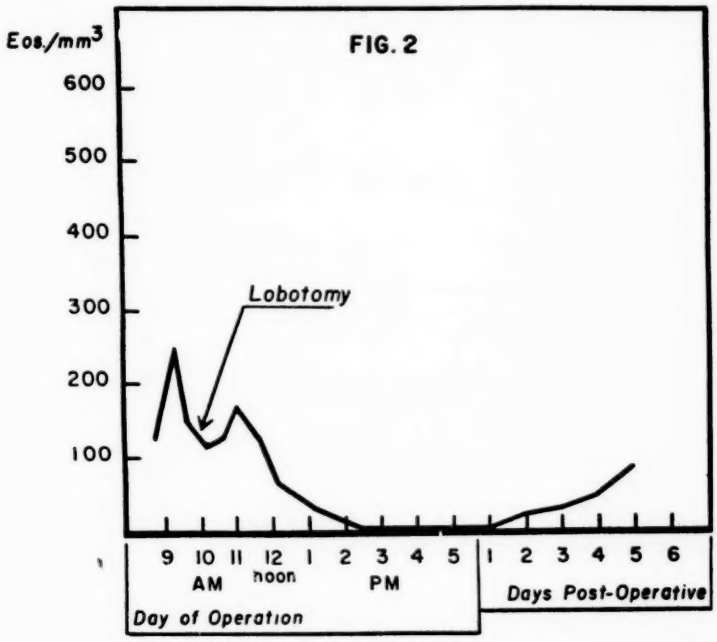
These studies, then, suggest that the adrenal output of 11-oxycorticosteroid and 11, 17-oxycorticosteroid is a part of the body's reaction to stress, the exact mechanism of which is as yet unknown. That adrenalin plays a part in this procedure by stimulating the adrenal cortex through the nervous system also appears probable. Some of the studies mentioned revealed an apparent difference from the normal in this mechanism in schizophrenia.[1-3, 6] Therefore, it was decided to investigate further into this difference by comparing the reaction of the adrenal cortex to epinephrine in schizophrenics with that in normal volunteers. Of the 27 patients chosen, most had been ill over five years. The 29 controls were state hospital employees of apparently normal mental standard.

In this experiment 0.3 mgm. of epinephrine was injected subcutaneously; and direct eosinophil counts were performed by the modified method of Dunger just before the injection and four hours



Reaction of eosinophil count to epinephrine injection in series of non-psychotic volunteers and schizophrenic patients.

later.[7] Figure 1 shows a tabulated record of the results in which there appears to be some difference between volunteers and patients. The former—while only 10 showed the drop of over 50 per cent described as normal by Thorn, et al.—differed from the schizophrenics in that only three of the patients showed more than a 50 per cent drop. The over-all distribution patterns, however, are similar. No significant correlation could be found between the subjective reaction to the drug and the eosinophil reaction in the

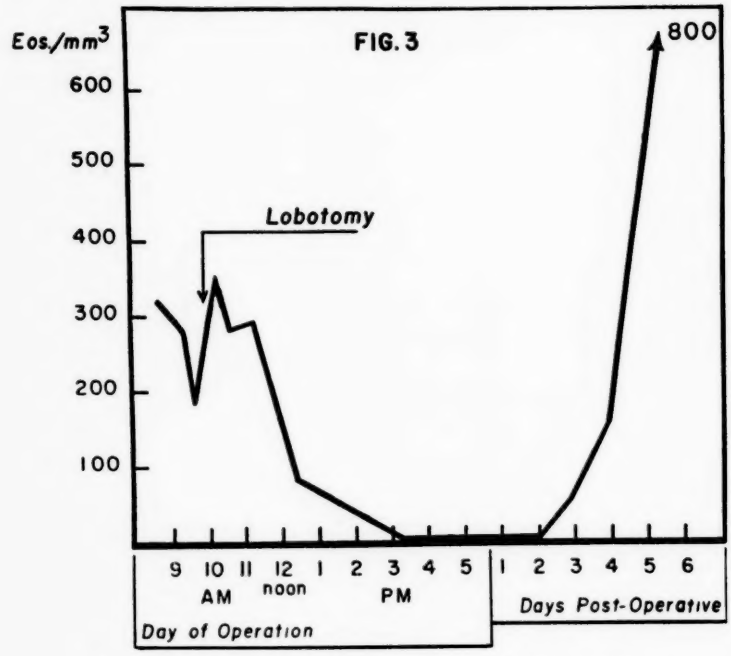


Reaction to lobotomy of eosinophil count of individual patient.

normal subjects. Almost all volunteers complained of some anxiety, while the patients voiced no such reaction. The fact that they were withdrawn and regressed schizophrenics for the most part must be taken into account when considering evaluation of these subjective symptoms.

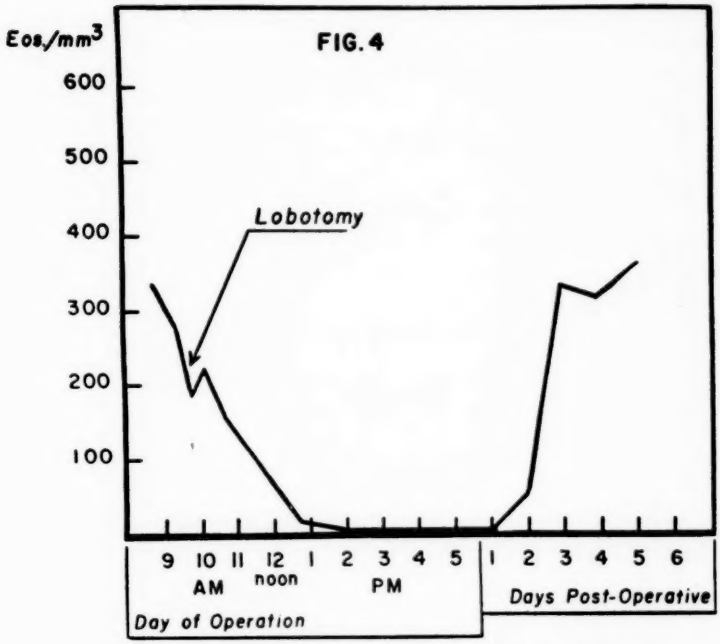
With the foregoing findings in mind, it was decided to determine eosinophil response in schizophrenic patients to a more severe

stress situation. For this purpose operative procedures were chosen, and the reactions to lobotomy were studied. These all followed a definite pattern of an initial sharp rise in circulating eosinophils followed by a sharp drop within six hours to a complete disappearance of these cells from the blood stream. The level remained at zero for one to two days and then returned to



Reaction to lobotomy of eosinophil count of individual patient.

pre-operative levels or higher. No regular concurrent changes in behavior were noted; none of the patients improved sufficiently to leave the hospital at a later date. These reactions are noted graphically in four individual patients in Figures 2 to 5 and are similar to the responses obtained in non-psychotic individuals during and after abdominal operative procedures as reported by Roche, Thorn, and Hills.[8]



Reaction to lobotomy of eosinophil count of individual patient.

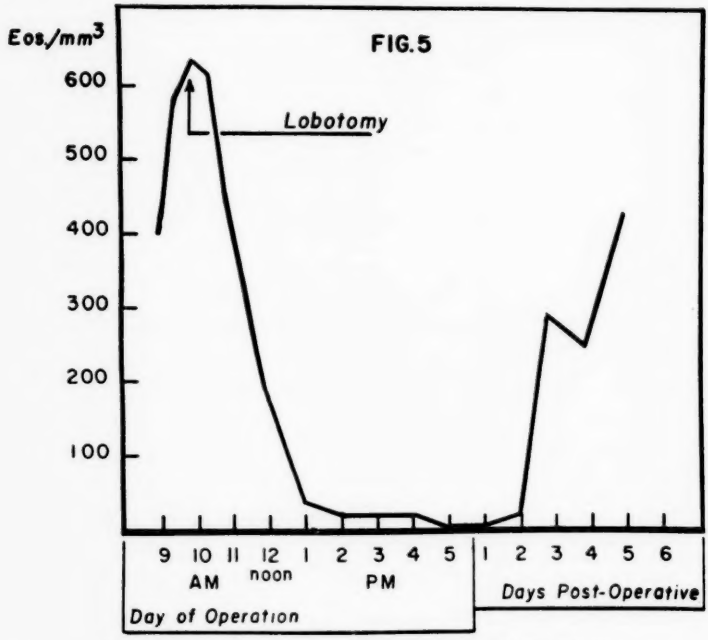
That this response was not caused by the pentothal anesthesia employed was shown by testing a series of schizophrenic patients during and after dental extractions and prolonged dental work performed under this anesthetic. They showed no marked changes in circulating eosinophils. (Figure 6.)

The eosinophil reaction to adrenalin was compared before and after lobotomy, and no significant or constant change was noted in this reaction as the result of the severance of the fronto-thalamic fibers.

Discussion

The work done by Pincus, et al., tends to show a difference in the adaptation reaction of schizophrenic patients from that found in the non-psychotic. The results of the pursuitometer and heat stress experiments show this difference as well as the studies in the differences between these groups in diurnal variations in cir-

culating lymphocytes. The over-all difference between psychotic and non-psychotic, in relation to eosinophil reaction to a given amount of adrenalin reported in this paper, is not suggestive of any constant difference in this adrenocortical reaction in schizophrenia. When a severe stress situation appeared in the form of lobotomy, the reaction in the schizophrenic patients was typical of that seen in the alarm reaction, and as seen after electric convul-



Reaction to lobotomy of eosinophil count of individual patient.

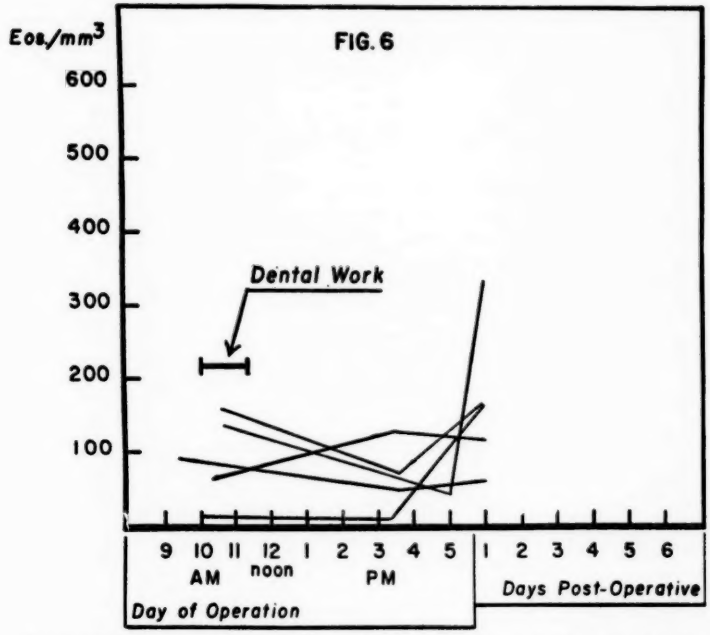
sive therapy or after any major operation on non-psychotic individuals.[9] The immediate rise, followed by a sharp drop, in eosinophils, suggestive of a marked output of 11 and 11, 17-corticosteroids, is identical to the usual shock and counter-shock phase of the alarm reaction in the adaptation syndrome as described by Selye.[10] Therefore, any alteration possibly present in the schizophrenic's adaptation reaction is not one which would interfere with the immediate response to acute stress situations. The fact that the eosinophil reaction to adrenalin was not altered by lobotomy sug-

gests that the frontothalamic pathways play little if any role in the body's reaction to stress. This has also been shown by previous work demonstrating that the adaptation mechanism was not altered by cortical anesthesia.[10]

Conclusions

1. Schizophrenia does not alter the eosinophil response to operative procedures—in this case lobotomy.

2. Lobotomy does not appear to affect the adrenocortical reaction to adrenalin.



Eosinophil counts of series of schizophrenic patients during and after dental work.

3. No significant difference was shown in the ability of schizophrenics to react to stress produced by adrenalin, as compared to non-psychotic individuals.

10 Bobolink Lane
Levittown, N. Y.

REFERENCES

1. Hoagland, H.; Elmadjian, F.; and Pincus, G.: Stressful psychomotor performance and adrenocortical function as indicated by the lymphocyte response. J. Clin. Endocrin., 6:301, April 1946.
2. Pincus, G., and Elmadjian, F.: The lymphocyte response to heat stress in normal and psychotic subjects. J. Clin. Endocrin., 6:295, April 1946.
3. Elmadjian, F., and Pincus, G.: A study of the diurnal variation in circulating lymphocytes in normal and psychotic subjects. J. Clin. Endocrin., 6:287, April 1946.
4. Speirs, H. S., and Meyer, R. K.: The effects of stress, adrenal, and adrenocorticotrophic hormones on the circulating eosinophils of mice. Endocrinology, 45: 403, October 1949.
5. Thorn, G. W., et al.: Studies on the relation of pituitary-adrenal function to rheumatic disease. N. E. J. Med., 241:529, October 1949.
6. Pincus, G., and Hoagland, H.: Adrenal cortical responses to stress in normal men and in those with personality disorders. Am. J. Psychiat., 106:641, March 1950.
7. Hills, A. G.; Forsham, P. H.; and Finch, C. A.: Changes in circulating leukocytes induced by the administration of pituitary adrenocorticotrophic hormone (ACTH) in man. Blood, 3:755, July 1948.
8. Roche, M.; Thorn, G. W.; and Hills, A. G.: The levels of circulating eosinophils and their response to ACTH in surgery. N. E. J. Med., 242:307, March 1950.
9. Altschule, M. D.; Altschule, L. H.; and Tillotson, K. J.: Changes in leukocytes of the blood in man after electrically induced convulsions. Arch. Neurol. and Psychiat., 62:624, November 1949.
10. Selye, H.: The general adaptation syndrome and the diseases of adaptation. J. Clin. Endocrin., 6:117, February 1946.

ACCEPTANCE IN THE THERAPEUTIC SITUATION

BY ALFRED T. BUTTERWORTH, M. D.

Psychotherapy has been defined by many disciplines and many individuals as many things and has never been adequately formulated. The exact nature of the healing process has been probed both intellectually and emotionally by various schools of thought, often with confusing and conflicting results. It is the purpose of this paper to elaborate and re-define the limits of only one factor, acceptance, which is believed to be an important process by all schools.

Ziskind defined the specific factors in psychotherapy and elucidated on the non-specific processes, concluding that the specific approaches urged by some therapists appeared in most instances unwarranted and at best not clarified.[1] He found that clinical reports submitted by practitioners of various psychotherapies showed the utilization of many non-specific factors. These non-specific processes he listed as: rapport, suggestion, ventilation, education, de-sensitization, and rehabilitation. All methods also made use in some form of the acceptance of the patient by the therapist—a certain tolerance of the whole individual which the patient is made to feel emotionally.

Rapport, one of the more basic of the non-specific processes, is certainly dependent on such acceptance in therapy.

The patient's need for acceptance and approval can also become the primary motivating force in the briefer forms of psychotherapy, such as are necessary in the large institutions, where temporal considerations are of importance. In the deeper-insight therapies, the therapist is strongly motivated, but the process is a long uphill climb for the patient, so that the patient's need for toleration is also helpful. It is noted, however, that where time is limited, as it is in institutional work, psychotherapy must necessarily be aimed at frank ego-building and must leave the deeper-insight therapies for their task of the more complete uncovering and integrating processes and techniques.

Where there is expectation that a minimum of uncovering therapy is to be used, acceptance as a help in ego-building is of greater benefit. Acceptance, in order to be actually perceived and broadly utilized by the patient, cannot be limited by formal patient-doctor

relationship, but must of necessity encompass all roles played by the two or more individuals concerned. These individuals, other than patient and doctor, may be trained observers, functioning as consultants, who may aid the therapeutic process. Whitaker, Warkentin and Johnson, in their experiences in multiple therapy where two or more therapists are used, have found that the method intensifies and speeds the help given to the patient.[2] This is possibly due to the fact that the patient is able to meet several members of the intrapsychic family at once. Whitaker has also pointed out the value of frequent consultation based on this work.[3]

Wolf and Wolff, in pointing out the worth of psychotherapy as done by the internist, note the value of acceptance by the therapist as the most universally practised and practical help for the patient.[4] They define the therapeutic relationship as the human warmth of the physician directed toward enhancing the strength, faith and determination of the patient, as well as toward releasing inhibitions and repressions. This, of course, implies an understanding and tolerant attitude by the therapist, and includes recognition and praise for the assets, potentialities, and achievements of the patient. This also involves an answering interest in, and a concern for, whatever the patient is preoccupied with at the moment. The physician, then, whether he be internist or psychiatrist, must be particularly careful not to express contempt, ridicule or disapproval, directly or indirectly, by word or by gesture, and must be able to accept the total personality.

The meaning of acceptance in the therapeutic situation may then be that the therapist—or therapists—has regard and toleration for the patient in all spheres, such as, for example in the social situation, and that the patient becomes aware of this rather intensely. It has long been assumed, of course, in most orthodox psychotherapeutic approaches that acceptance in the aforementioned sense is not only impossible but undesirable, yet acceptance in the limited senses of tolerance, permissive attitudes, objectivity, establishment of rapport, lack of moralistic judgment of the patient, is always freely used as a valuable non-specific adjunct in all therapies. It is true at the same time that in the deeper analytic situation, analysts must necessarily remain limited to neutral observer-participants, for the projection of affect of unconscious material. However, for more non-specific treatment, it follows

that, possibly, a wider limitation of the doctor-patient relationship might be helpful in establishing effective therapy.

Patients of all types who consult psychotherapists have one problem in common, in that they all are aware of merely a portion of self. This is true by reason of, not only repressive forces, but also those of conscious suppression. For many reasons, the patient may find, to give one example, that he must protect the prestige of self in the presence of a certain other individual. Various roles are played by the patient in the presence of various individuals who play, in their turns, various roles in various situations. The neurotic is quite unable to become aware of self as a totality and can only view himself as parts and roles—planes and limited areas on the admitted surface of the personality. Great discomfort, suffered as anxiety and fear, is felt by the neurotic when an attempt is made to force him into roles and to reveal other parts of his personality, at what he considers inappropriate moments with inappropriate individuals. The neurotic patient in his interpersonal relations reacts to a given individual, in a given role, in a given situation, in a quite rigid manner, for reasons which may be somewhat obscure to the therapist until a much later date, if they are ever clarified. The revealing of these reasons, the real etiological factors, in such a manner that the patient is able to handle and integrate them into his total personality, is the task of the more specific and deeper therapies. But, surely, the opportunity to play all roles unhindered is a valuable and instructive emotional experience for the patient. This fact has been clinically observed with other methods of therapy, such as psychodramatic sessions. The interpretation by the patient's integrating psychic force of acceptance in a broader sense is found clinically to be helpful instantly in giving actual comfort and a feeling of well-being to the patient, although this may be merely the perceiving of consciously-suppressed portions of the whole person. The identification of the patient with the therapist also brings a strengthening of ego; and the acceptance of the therapist as a whole person—and, therefore, the acceptance of other significant figures in the past—cannot be overlooked as a helpful process in therapy. The admission of unconscious material is easier later and is certainly important in deeper therapy.

The difficulties for the therapist in applying wider limits of acceptance, are, of course, great but not insurmountable. It is necessary, however, to estimate the more specifically defined limits of the relationship with greater care than is exercised in more narrow relationships. A close observation of the patient during the early interviews—not only alone with the therapist, but with other trained observers in consultation, with members of the patient's family, and with friends—can help in determining the facets of personality and character in the various roles commonly played by the patient in relation to the situation. The therapist may then choose his own roles, which may then be displayed for the purpose of eliciting the total personality of the patient. The problems of countertransference in this method are of course multiplied and intensified; and the flexibility of the therapist is greatly strained. Here again, the therapist is able by the gradual shifts in his role from the social to the "orthodox" doctor-patient relationship to confront the patient with the latter's own rigidity. At the same time it is found possible to acquaint the patient with himself and the therapist as whole individuals. This is a new experience likely to be helpful to the patient emotionally. In this sense, acceptance means that the therapist can function with the patient in any given role such as, socially, in a servant-master relationship, a father-offspring situation, etc. This relationship is unlimited, except by the limitation set by the therapist when he evaluates the problem of the patient, in attempting to elicit all roles played by the patient for acceptance.

These procedures are actually put into practice on one of the services at a hospital in a large city in both the out-patient department and the neuropsychiatric in-patient service. The results, in the establishment of a good relationship between the patient and hospital, and in the reduction of time required for the patient to make a social adjustment, demonstrate the benefit of acceptance of the patient on a multiple basis. The patient, on admission to the in-patient service, is interviewed by the resident physician and intern. Nurses on the ward then meet him. Shortly after this, he meets the visiting staff physician for further interviews. Later he is assigned to a student physician who completes a formal examination and formulation of the patient's problem. He is later

seen by the chief of the neuropsychiatric service. He may then be presented to the entire section of student-physicians who are primarily concerned with clinical work in neuropsychiatry, some 15 or more individuals. In this conference, which is attended by visiting staff physicians, student-physicians, resident physicians, social workers, interns on the service, clinical psychologists, and occupational therapists—a total of 25 to 30 individuals—the patient is gently and tactfully interviewed by the chief of service initially and later by other members of the group. He is never made to feel humiliated by a demonstration technique; but, on the contrary, perceptibly warms emotionally to the group, first playing one role and then another. It is as if the patient feels that he is contributing something to the group effort; and he reacts positively to the generally-accepting attitude of the group and to its individuals. This obvious relaxation and support, where the patient finds tolerance for the total self, is remarkable to a person who has experienced only rejection in his real family—which has adopted a rigidly moralistic attitude toward at least some portions of his personality.

The patient who comes for out-patient clinic visits, first meets the nurses, clinical clerks and social worker. He is assigned to a student-physician who examines and evaluates him under the supervision of a visiting staff physician who later meets the patient for further interviews. Although the student-physician is only in contact with the patient for the short period of eight weeks, there is no real handicap for the patient, since the continuity of the acceptance on a multiple basis is maintained because of the permanent personnel of nurses, staff physicians, resident physicians, etc. In this setting too, the acceptance of the total personality is a great factor in helping the patient to tolerate self in society.

The limits of this approach are obviously not rigid boundaries but are only determined by thorough study of the patient to determine the real potentials and possibilities of the total personality. This can be regarded as simple and early ego-building and as a step in the later, more complex and difficult, specific, uncovering therapies. No contraindications are found for this later work and indeed further therapy is facilitated and speeded. The patient is still capable of feeling the transference situation and transference

neurosis but in a more varied and perhaps more therapeutically-fruitful manner. Consultations are freely used, both early and late in the treatment, not only as an early help in eliciting roles, but for later help with more rigidly-typed therapists.

Department of Neuropsychiatry
Louisiana State University Medical School
New Orleans, La.

REFERENCES

1. Zisknd, Eugene: How specific is psychotherapy? Am. J. Psychiat., 106-285, 1949.
2. Whitaker, C. A.; Warkentin, J.; and Johnson, N. L.: A philosophical basis for brief psychotherapy. PSYCHIAT. QUART., 23:425-443, 1949.
3. Whitaker, C. A.: Teaching the Practicing Physician to Do Psychotherapy. Unpublished.
4. Wolf, Stewart, and Wolff, H. G.: Notes on a symposium: the internist as a psychiatrist. Ann. Int. Med., 34:212-216, 1951.

ADMINISTRATION OF THE CONTINUED TREATMENT SERVICE

BY LESTER E. SHAPIRO, M. D.

The continued treatment service, more than any other section of the state hospital system, bore the brunt of World War II shortages. As hospitals suffered greater and greater depletion of medical and attendant personnel, the shortages on the active services were replaced by personnel drawn from the continued treatment services. This, of necessity, increased the patient-doctor ratio in the latter section to the point where the continued treatment service sometimes approached the point of becoming that in name only and, in actuality, offering only custodial care. The purpose of this paper is to offer a plan of administration of the continued treatment service which will revive interest in this type of service and will demonstrate the practical therapeutic measures that can be introduced. The material on which this paper is based is the result of two years application of such a program in a 488-bed continued treatment service building in one of the larger New York State hospitals.

The *sine qua non* of a properly-run building is the proper classification of patients. Helter-skelter assignment of patients by ward vacancies, rather than by behavior and ability to assume interpersonal relationships, was a direct result here of the factors mentioned in the first paragraph and the rectification of this situation was the first step undertaken. The building in question consists of eight wards, each having a census of 61 female patients. The wards were assigned as follows: two of "assaultive patients," one of "noisy," one of "wetters and soilers," one of "seniles," one of "workers" and two considered "bon ton." Each patient was interviewed, her ward notes were checked, and the opinions of the staff attendant and supervisor were obtained. In the interest of speed, clinical notes were not made at this time. It was found necessary to re-classify some 150 patients. Preparations, such as the transfer of clothing and personal belongings, took several days; and, when these were completed, the actual transfer of patients was carried out.

Prior to the transfer, the patients had been told of the proposed changes and the reasons for them. In spite of the fact that these changes were rather sudden and drastic, in not a single instance

was an adverse effect noted. This point is stressed in view of the rather widely-held opinion that reorganizations of this sort should be carried out gradually over a relatively long period.

The geographical location of the wards was considered. The building housing them is of two stories, with four wards on each floor. Two wards comprise a wing, and there are central areas separating the wings. The two "assaultive" wards were placed in one wing on the ground floor. The senile ward and the wetters' and soilers' wards were placed in the other downstairs wing. The workers' ward, the two bon ton wards and a "pre- bon ton" ward were placed on the upper floor. In this way, the better wards were almost entirely out of contact with the more regressed. Further, the former did not have the psychological burden of living underneath patients who, at any time, might pour dirty scrub-water, apple cores, etc., from their windows, or bang hardwood furniture overhead. The installation of the regressed wards on the lower floor facilitated the going to and from the dining room of the regressed patients, and, in addition, enabled the arranging of dining room hours so that there was minimal contact between the patients of the two floors.

At this point, three basic principles and their application will be mentioned: (1) the utilization of available space to its fullest capacity; (2) similar utilization of patient help; (3) the taking of calculated risks with patients. In line with this, several empty center rooms on the second floor were taken over and developed into "projects" for the building. One was converted into a library, another into an occupational therapy "preparing room," a third into a knitting room, a fourth into an occupational therapy room and a fifth into a beauty parlor. All these projects are operated by patients.

The building inventory of furniture was not increased to furnish these rooms; rather, a table and two chairs were taken from each of the wards. Simply-constructed bookcases were obtained from the carpentry shop, and furnishings such as rugs, wall-hangings and the like were initially obtained from the occupational therapy department; these were subsequently supplemented with materials produced in the building.

The library was supplied with books discarded from the main hospital library and with magazines provided by attendants and visitors. When it became apparent that the building library had

proved its usefulness as indicated by the fact that the circulation of books had increased five-fold following its installation, it was promoted to the status of a circulating branch of the main library. There are some 400 books in the building library, of which 50 are turned back to the main library every two weeks in return for others. Magazines are always in demand there, with approximately 150 in circulation at any given time; picture magazines such as *Life* and *Look* are in particular demand on the disturbed, regressed and senile wards. On these wards, the average useful life of a magazine is from three to seven days; and it requires some 50 magazines a week to maintain the supply. In spite of rather strenuous efforts, it has not been found possible to get regressed or assaultive patients interested in reading books. On the better wards, there has been no such problem, there is an average of 50 to 75 books in circulation at any given time. Here the magazines enjoy a greater longevity and such magazines as *Readers' Digest, Colliers* and *Saturday Evening Post* pass from patient to patient. The library is open from morning until bedtime and is maintained by two patients who keep a simple listing of books going in and out. They have the key to the room and are encouraged to use initiative in making the library attractive and in helping patients select their books. Patients are free to visit the library at all times.

In the occupational therapy preparation room, the planning and preliminary work on building occupational therapy projects are carried out. Here, for example, slipper patterns are cut, potholders basted, frames strung, etc. The raw material is obtained from the hospital occupational therapy department, and the building occupational therapy program is under the over-all supervision of a trained therapist who spends three mornings a week in the building. The occupational therapy preparing room is in the hands of two patients, usually alcoholics who are well enough to be entrusted with scissors, etc. They have the key to the room, which is open from morning until suppertime.

At this juncture, the general attitude toward occupational therapy might well be mentioned. The writer considers it to be one of the major forms of treatment available in a service of this type. He feels that it provides a means of contact with reality both by the very nature of the work and by the personal interest taken by the therapist in the individual patient. Further, it acts as a stim-

ulus to group activity when, as is emphasized in the present instance, the work is channeled in the direction of ward projects such as bedspreads and chair backs. In this manner, too, a community feeling toward the ward and the building is engendered. Finally, the realization by the patient that she is able to do constructive work tends to break down the all-encompassing lack of confidence that institutionalized patients so consistently show.

Several types of occupation are available:

1. *Ward Occupational Therapy.* On an average, 100 patients are engaged in ward occupational therapy daily. On each ward, a well-integrated patient is assigned to the task of supervising the work. Where, as on a disturbed ward, such a patient is not available, one of the patients from a better ward is loaned to that one during the day. Each of these patients spends a week or two working under the supervision of a trained therapist before taking over a ward assignment. The over-all responsibility for ward occupational therapy rests with the attendants. They, too, undergo a period of training in occupational therapy. The ward program is aimed at improving the appearance of the building by making curtains, scarves, etc., and not toward the yearly occupational therapy sales. This is an aspect of the program that cannot be too strongly stressed. The better patients are particularly interested in making things that will improve the ward appearance; and they co-operate wholeheartedly in the program. Rugs, slippers, pot-holders, etc., are made on the "assaultive" wards; here an attempt has been made to have the patients work in "social groups." However, while the physical form of this has been realized, with the patients sitting in circles around tables, not much headway has been made in the attempt to have them establish interpersonal relationships with one another, as contrasted to the signal success in this endeavor on the better wards.

2. *Occupational Therapy Shop.* The occupational therapy shop is under the supervision of a trained therapist. Here some 30 patients work during the mornings. They are sent there with a definite therapeutic objective in mind. For example, some of them are undergoing symptomatic shock therapy; and it is felt that the opportunities to get away from the ward, to come into contact with a sympathetic therapist, and to regain confidence by engaging in a relatively superior type of occupation, are valuable adjuncts to that type of therapy. Another type of patient who has benefited

by assignment to the occupational therapy shop is the cyclical patient whose periodic disturbances can be headed off or aborted as the result of a week or two in the shop. It has also been noted that patients in the initial stages of regression—as manifested by a tendency toward seclusiveness, idleness and neglect of personal appearance that contrasts sharply with their excellent contact and relatively clear ideation—can be maintained at a very satisfactory level in the shop.

3. *Building Projects.* Assignments to the library, the occupational therapy preparing room, beauty parlor, ward occupational therapy supervision, and knitting-room supervision are given to patients who, in addition to having the ability to handle the jobs, also require superior employment to counteract the vitiating effect of institutionalization.

4. *Hospital Industry.* Patients assigned to work in hospital industry are chosen from the standpoints of relation to their previous social and economic levels. It is felt that an occupation below one's level may be traumatizing at certain stages of mental illness. Hence, patients are carefully selected for work in the laundry, dining room, etc. The factors considered are the type of the illness, duration and course of the illness, and the patient's previous social and educational level.

The results of the occupational therapy program have been most gratifying. From the standpoint of statistics, more than 100 patients are employed daily in ward occupational therapy, some 70 employed in hospital industries, 50 as ward domestics and 20 as ward occupational therapists or project supervisors. The patients in this last group have benefited immensely. They have developed feelings of personal achievement that have been buttressed by their being placed in positions of responsibility. Further, they have developed a "feeling" for the building, which they have conveyed to all but a handful of paranoid patients. Regarding the use of patients as ward domestics, it is felt that where they are carefully selected and where care is taken that they are supervised with consideration, this practice is justified, as it releases attendants to perform the type of work that is expected of them in a progressively-oriented building: the giving of sympathetic care and attention to the individual patient and the organization and supervision of constructive activities on the ward. This point will be taken up again.

Another project for the building is the beauty parlor. This was formerly located in the basement, a site which proved to be unsuitable. It was moved to a vacant room on the second floor. This has proved advantageous, as it obviates the need of having attendants shepherd patients to and from the parlor. Further, the patients enjoy the opportunity to look in on the work. Patient-beauticians work under the supervision of a trained beautician. Owing to the heavy load, one item a week is allowed. Patients are treated on an appointment basis, and those on the second floor come to the shop unattended. In addition to the work performed in the beauty parlor, attendants are encouraged to set hair, give manicures, etc., on the wards.

The need for elasticity in the type of program under discussion is illustrated by the following. Initially, one of the rooms was set aside as a game room and the floor was laid out for deck tennis and ring-toss. However, very little interest was shown in the games, and the room became a place where the more regressed patients would go to lie on the floor unnoticed. An attempt was, therefore, made to convert it into a sewing room where it was hoped that state clothing and private clothing would be repaired by patients. However, because of the shortage of attendant help and consequent poor supervision of the project, it did not work out as planned and had to be dropped. Recently, a class in knitting was installed there under the supervision of one of the better patients. This has proved most successful from every standpoint. Another room that had been the site of various unsuccessful projects was finally placed in the hands of an alcoholic who had sufficient drive and imagination to convert it into a small occupational therapy shop. Here, dolls, 'kerchiefs, and almost anything else that this enterprising patient can contrive, are made; and employment is given to half a dozen patients in a truly socializing atmosphere.

In all, five rooms are being utilized. These lead from a central area which has been converted into a lounge by the use of wicker furniture, table scarves, wall hangings, rugs and a piano. The latter serves as a focus for group singing and is almost constantly in use. Only once in the past 12 months has it been damaged by a disturbed patient. There are four wards on the second floor, and the doors from three of these are open at all times. The patients

feel less confined, can visit one another and take advantage of the facilities available in the center.

One of the basic principles that underlies this policy is that of decentralization. In line with this, a non-denominational religious service is held in the center on one morning a week. The turn-out has been gratifying. Whereas there formerly were only 15 patients attending the general hospital services, there are over 50 attending the building services each week. In addition, the number attending the hospital services has more than doubled. Aside from these figures, the real value of this program has been the rapport that has been established between the "congregation" and the minister, and the manner in which this type of service has reduced to a minimum friction among the various faiths. As another instance of decentralization, building parties are held every two weeks. The arrangements are placed in the hands of a committee of patients. Checkers, dominoes, bridge, etc., are played, and the committee takes it upon itself to assign patients to coach the more regressed ones in the playing of these games. Parties are held in the dining room and are attended by well over 100 patients. They are held on days when ice cream is part of the luncheon menus. By the simple expedient of serving smaller portions at lunch time, enough ice cream is saved for the party. Similarly, crackers for the occasion are put aside from the regular rations.

From what has been said in the foregoing, it is apparent that there must be co-ordination between a continued treatment service building and the reception service, so that the physician in charge of a continued treatment service can request the type of patient he requires for a particular project. This leads to the consideration of another basic requirement: namely, that patients come from reception on the basis of the ward vacancies of the continued treatment service, rather than on the basis of over-all building vacancies. Nothing breaks down a properly-classified building so much as the transfer of disturbed patients when vacancies exist on a good ward. For proper functioning, a continued treatment service should have an absolute minimum of 2 per cent vacancies at all times. Dovetailing with this, is the need to recognize the fact that a continued treatment service building is a mental hospital in itself. One would consider it impractical to designate a hospital as being solely for the care of disturbed patients; surely

the same reasoning should hold for a continued treatment service. Patients are needed to supervise occupational therapy, to run the library, to provide acceptable dining room help; and there is a mutuality of benefit that both the patients so employed and the building derive from such a plan.

The better utilization of space has been mentioned, but requires further comment. In most buildings there is surplus space that is going to waste or is not being used to best advantage. There are rooms that are being used for storage space, or in other unproductive fashions that can be converted for the use of active, constructive projects. In the present instance, the rooms taken over had been designated as quarters for employees but had been in disuse for several years. The center had been designated as a visitors' room; but it was felt that this area could be better utilized by patients; and to replace it on visiting days, a ward is now cleared of patients. In line with the policy of proper utilization of space, the dayrooms have been rearranged. The often-seen arrangement which places the chairs and benches along the walls in such fashion that they surround a highly polished, flower-potted central area which is "off-limits" to the patients has been done away with. Instead, the chairs and tables are arranged in club style; magazines and games are placed on the tables; and the flower pots have been set on wooden stands.

Resistance of attendants to change along progressive lines presented a formidable problem initially. It was difficult to effect a change in the traditional attitude which called for custodial care with exclusive emphasis on polished floors, bathing days, records, accident reports, regimentation of patients, and rather perfunctory interest in the human and humane aspects of the job. Some attendants had been going through the motions for 15 years and simply resisted change. Others feared the relaxing of patient-discipline that is inherent in a progressive policy. Others rebelled against the amount of extra effort they thought the program would entail. Finally, there were some who did not have the personality qualifications to gear themselves to such a program. Fortunately, there were several who welcomed the opportunity to improve conditions.

The co-operation of the others was achieved in the following ways: 1. Group meetings were held with the attendants to explain the objectives. 2. Attendants were transferred to the types of

wards that best suited their personality make-ups. 3. Employees who either could not or would not fit into the program were transferred from the building. 4. All newly-employed attendants were given an orientation talk by the physician, taken for a tour through the building and given an understanding of their part in the overall program. 5. Front-office support for the program was, fortunately, most energetic; this did much to ensure the initial co-operation of the attendants.

As the plans took shape and their value became apparent, co-operation became spontaneous and wholehearted.

The proper orientation of the physician toward his position in the continued treatment service set-up is of paramount importance. His position is unusual in that the proper discharge of his duties requires that he be physician, psychiatrist and administrator. All too often, the latter role is considered beyond, or possibly beneath, his scope. The proper care and treatment of his patients demands that the physician interest himself in such details as the provision of clothing, proper dining facilities, the punctual dispatch of mail, proper organization of entertainment and so forth. In the group therapy sessions, which are an important part of the program, it was found impossible to obtain rapport if patient-resistance had been engendered by lack of silverware in the dining room, failure of the laundry to return on time or by some other seemingly trivial matter whose importance to the peace of mind of the institutionalized individual one is apt to overlook.

An important part of administrative duties is the selection of patients for family care. A fair number of chronic patients can adjust well in the family care situation; and the physician should not only be on the alert for suitable patients, but should visit the homes, become familiar with the types that are available, and select patients accordingly. Further, he should be in a position to give both the patients and their relatives a first-hand account of the program.

Although a discussion of symptomatic shock therapy is not within the scope of this paper, it is mentioned as another therapeutic measure undertaken as part of the general plan. It has been of definite value in treating acute behavior disturbances in chronic cases and in obtaining behavior improvement in deteriorated cases. It has also helped to improve employee morale by contributing to the removal of the stagnant atmosphere of help-

lessness and hopelessness which is characteristic of regressed wards.

The results of the program outlined have included matters that can be measured statistically, and some that are more subtle but of greater importance. Some of the figures have been noted throughout this paper. The more gratifying results, however, have been the changes in attitude, the reawakening of interests, the regaining of confidence and the re-assumption of interpersonal relationships that have been noted in the patients. Patients now regard the building less as a place of confinement than as a community having a definite therapeutic objective. There is a better understanding of, and tolerance for, the actions of disturbed psychotics; this has been manifested both by the attendants and, of even more importance, by the patients.

The release rate under the present program has been 15 per cent higher than in the last previous year. However, as the number released under the new program was only 38 a year and, too, as so many variables enter into the release rate, it is not felt that any substantial gain can be claimed in this direction. The most significant gain has been in the very definite fact that during the year there has not been a single instance of even early regression seen in a previously "well-retained" patient. The writer feels that over a five-year period, the percentage of regression and the degree of regression under this program will be substantially less than in the previous five-year period.

To summarize: The continued treatment service has tended to lapse toward a custodial department. An organized effort is needed to reawaken interest in the progressive treatment of the chronic patient. A plan has been offered which has proved its value in the course of two years' application. The general principles are applicable to all continued treatment services. These general principles are:

1. The proper ward classification of patients from the standpoint of behavior and ability to assume interpersonal relationships.
2. The location of wards so that there is minimal contact between the disturbed and the better-integrated patients.
3. The utilization of empty rooms and other available space for the creation of projects for the building, such as library, beauty parlor, lounge and knitting room.

4. The utilization of patients to organize and supervise the various projects. In line with this: (a) It is felt that each continued treatment service building should be considered a miniature hospital and hence have its quota of convalescent wards. (b) There must be co-ordination between reception and continued treatment service, so that the latter's requirements receive due consideration when patients are transferred.

5. The decentralization of the larger institutions so that each building may become, as far as possible, a compact unit with its own recreation facilities, parties, dances, etc.

6. The encouragement of occupational therapy not only in occupational therapy shops, but on the wards; the projects to be aimed at use for the building and its patients, rather than for sales.

7. The utilization of symptomatic shock therapy.

8. The utilization of group therapy.

9. The adequate knowledge of and supervision of the building housekeeping by the physician.

10. The proper application of the family care program.

11. The proper education of attendants as to their function in a truly therapeutic psychiatric program.

In conclusion, the writer would like to stress the fact that the adoption of the program requires the active and energetic support of the administrative officers of the hospital. Without this support, the program reported here could not have been carried out.

32 Wilson Lane
Rockville Center, N. Y.

THE GENESIS OF SCHIZOID PERSONALITY: A STUDY OF TWO CASES DEVELOPING SCHIZOPHRENIA*

BY B. W. MURPHY, M. B., Ch.B.

The etiology of schizophrenia is still uncertain, despite a vast amount of research and therapy. Many investigators approach the problem at a somatic level, in terms of cellular pathology, endocrinology, electro-encephalography, genetics. However an increasing number of workers, emancipated from sterile Kraepelinian formulations, have ceased to regard schizophrenia as primarily an organic disease. These advance the concept of schizophrenia as a disorder of interpersonal relationships, arising out of traumatic conditions of early life, and developing as a result of long-continued frustration of needs, or as a result of sudden threat in later life. These views, and reports of therapy based on them, have been stated compellingly by Sullivan,[1] Fromm-Reichmann,[2, 3] N. Cameron,[4] Shulman,[5] Betz,[6, 7, 8] and others. It is not the purpose of this paper to re-state these conceptions, but to report the occurrence of schizophrenia in two young women who were exposed to similar pathogenic experiences in early life. The two patients were of different parentage, but were adopted in infancy and reared by the same foster parents.

The general background of these cases is as follows:

The foster parents, for undetermined reasons, were not able to have children of their own. In 1915, the foster mother without prior consultation with her husband, went to an infants' home in eastern Canada and adopted the first child, P., at three weeks of age. Two years later, she adopted the second child, J., at six weeks of age, from the same infants' home. The adoptions were accepted by the foster father, and the children were reared as their own and not informed as to their adopted status until adulthood.

P. became frankly psychotic in 1943 and was committed to the Provincial Mental Hospital, Essondale, B. C. J.'s psychotic symptoms began in 1948, and she was admitted voluntarily to the Crease Clinic of Psychological Medicine, Essondale, in 1950. The writer had the opportunity to interview J., whose case is reported in the greater detail. P. had been discharged by the time the matter was

*From the Crease Clinic of Psychological Medicine, Essondale, B. C.

under investigation. The material concerning J. was obtained from personal interviews, from her psychiatrist, and from social service reports. Information about P. comes largely from hospital case records and social service reports. The foster father was interviewed personally, and there was correspondence with the foster mother who is now living some distance from the hospital. Information was obtained from the infants' home where the children were adopted. Unfortunately, little could be learned regarding the real mothers, other than that they were both unmarried. No information was obtained concerning the real fathers.

Case 1

On admission in 1950, J. was 33 years old, married, and had two children, a girl and a boy, aged four and two. She gave the following chief complaints: "A certain amount of mental confusion and tension. . . . I've been depressed and I've had the feeling that people were down on me and talking about me—I still feel there's been a certain amount of talk and misunderstanding." In addition, there had been panic attacks, a feeling of constriction across her brow, and, just prior to admission, the belief that her relatives wished her death.

She considered she was last really well two and a half years previously—up to the time her son was born. Following the child's birth, she felt her doctor implied by his manner that he considered her a sexual pervert. She was distressed, but after she had allegedly ascertained from a druggist that the doctor was a drug addict, she discounted the incident.

Nothing of note is reported for a year following this, until her daughter's third birthday party, when she had a sudden anxiety attack. As the children began to sing "Happy Birthday" she felt horrified, about to cry, and rushed from the room. The attack passed, but a few days later her mother-in-law gave her a "dirty look," and J. concluded that her sister-in-law, E., had "said something" about her. A few days later, she felt terrified and feared she was going insane, phoned her mother-in-law and screamed, "I'm not Jewish; I'm not; I'm not; E. lied." Panic subsided, but J. became increasingly sure E. had defamed her and that many people were now talking about her in a derogatory fashion. "I thought people considered me cheap and trashy and not particularly intelligent."

She became increasingly anxious, irritable and liable to periods of depression. Preoccupation with the attitudes of others toward her, always one of her characteristics, increased. She lived in an atmosphere of antagonism and construed all manner of remarks as pointed and hostile.

In addition she began to "remember things." She remembered a Jewish doctor at one of the hospitals where she had been a nurse, and became convinced he was her real father. (She had been told she was an adopted child three and a half years prior to admission to the Crease Clinic.) She "remembered" a nursing supervisor saying to this doctor, "She's your own flesh and blood and the least you can do is protect her by staying away from here." A conviction appeared that she had been raped at the age of three by her foster father and called a "God-damned bastard Jew."

The anxiety, irritability and rumination continued, the relationship with her husband deteriorating to such an extent that he threatened to leave her on several occasions. She had a severe anxiety attack, with fear of impending death, and was admitted to a private hospital. Here she could not communicate with the psychiatrist, felt everyone to be against her, and felt that her husband's family wished her out of the way. She realized she was ill mentally and sought admission to the clinic.

Personal History. J. was adopted at six weeks of age. As a child, she felt her foster father to be an impatient, irritable, explosive man, rather disinterested in her and P. He "expected too much of us for our ages," and frequently shouted at them. J. believes he preferred P. She reports the foster mother as being a cold person who tried to be friendly and affectionate, but couldn't be. She was a meticulous housekeeper and insisted on the children being scrupulously tidy in the house. She was strict and repressive, arbitrarily restricting the girls' social activities. J. feels her behavior to them was motivated by a sense of duty, rather than affection.

All through her home life, the parents quarrelled and bickered constantly, with frequent physical violence. J. and P. often left for school in tears after witnessing a scene.

As a child, she frequently quarrelled with others and could never relate warmly or securely to her peers. "I could never make close friends. I kept my distance." She and P. were together a great deal, and in the early years got along well, but as they grew

older became more distant and did not share confidences or communicate freely. J.'s school record was satisfactory but she maintained emotional distance from associates.

She was aware of considerable sexual curiosity as a child, and reports an episode of mutual exhibitionism with a little boy, at about the age of six. She was unprepared for the menarche at 11, and was alarmed. There was an indefinite period of masturbation in adolescence, and she does not recall feeling guilty. About this time—at camp for two weeks—she had a fleeting "crush" on an older girl. Dating was prohibited by the foster mother until she was 17, after which she had several superficial relationships with boys, none of which was really meaningful to her. There was no sexual intercourse until marriage. She attained orgasm up to one and a half years before her clinic admission, at which time she became frigid.

On leaving high school, she entered a school of nursing and was graduated in 1941. She was happier living in the hospital than at home, but was habitually anxious before going on duty. She managed her work satisfactorily. Here again she could not form warm relationships, although it is known that the other girls found her attractive and wished to be more friendly with her. At times she would be found weeping in her room, but could not say why.

She met her husband through a mutual friend and after a year married him, feeling, "It was the sensible thing to do." He is a quiet, rather passive man, who has communicated poorly with her. He is closely attached to his family, a close-knit group of four brothers, their wives and his parents. J. has never felt completely accepted by this group. She felt that her husband had absorbed his father's patriachal values, and tended to regard her rather as a chattel. Certainly he exhibited little romantic behavior since marriage; and when she approached him for a demonstration of affection, he became anxious and indignant. He had been quite unable to handle the situation since her illness developed, attributing her behavior to "cantankerousness" and "being difficult." On three occasions, he threatened to leave her. It is noteworthy that she had been manifestly sick for 18 months before anything effective was done by him.

The husband is an architectural draftsman, and, although finances have been marginal at times, the couple have suffered no real deprivations. She has no religious affiliations and is nom-

inally a Protestant. She believes in the divinity of Christ, and that our hell is here on earth. She has given her children excellent care before and during her illness. They show no disturbances as far as is known.

Her physical health has always been good. She suffered two limb fractures in childhood and dysmenorrhea for several years after the menarche.

It should be mentioned that she was informed of her adoption about three and a half years before hospitalization, at the time her foster parents separated. She does not recall feeling anything other than a sense of relief on learning they were not her "real" parents, in that she felt guilty for not loving them as she believed one should love one's parents.

State in Hospital. On admission she was found to be a tense, quick-moving dark young woman, with an attractive mobile face. She smiled and laughed in appropriate fashion, and related readily to her psychiatrist and the writer, after a short period of reserve. Some manifest anxiety was noted, but she was not depressed. On the ward she was quiet and reserved but friendly enough when approached. She declared that she felt more relaxed with people than she had for years. She talked freely in interviews, and there was no frank schizophrenic disintegration of thought except when she touched on the obviously autistic material, at which time she would slip temporarily into a peculiar, garbled, psychological jargon. Ideas of reference, which had been rife previously, were not evident in the hospital, and she now felt she had undoubtedly misconstrued many innocent remarks when she had been so ill previously. She remained convinced that E. had defamed her. The notions concerning her "real father" were unquestionably delusional, and there were retrospective falsifications concerning the hospital experiences which involved him. The rape and verbal abuse at the age of three are almost certainly delusion.

She had coma insulin treatment, 45 comas in all, and psychotherapy, along the lines indicated by Betz[7, 8] with her psychiatrist. She felt much better in several weeks, and agreed that many of her ideas were probably fantasies. Her husband was seen by the psychiatrist and social worker. She was discharged after three months and is returning for further interviews. She now feels

much happier, more secure with her husband, and well in other respects, although at times she feels some remarks made to her are barbed.

Case 2

P. was committed to the Provincial Mental Hospital, Essondale, B. C., in 1943 at the age of 28. She was married and had a child 10 months of age. Committal followed the patient's spending a few days in a hotel with a soldier, at which time she was found to be childish, irresponsible and vague. Her illness had developed as follows.

Early in 1943, the foster parents noticed she was given to foolish, inappropriate smiling. She was withdrawn, disinterested, preoccupied, untidy and dirty personally. At this time she was living with the foster parents, her husband having joined the air force and left without making any provision for her. Because the foster father was antagonistic, she moved into a housekeeping room and soon wired her husband to come, on the pretext that the baby had a grave heart condition. He came, found his wife incapable of caring for herself or the baby, and removed the child, leaving P. to her own resources. It was then she became involved with the soldier. She was taken to the foster parents' home again, where she was restless, smiled constantly and spent long periods gazing into a mirror. Committal followed.

Personal History. The general outline of early development is similar to J.'s. P. was a very anxious child, "delicate," and had a variety of childhood diseases, including one called St. Vitus' dance. She was very detached, quiet, withdrawn, and more passive than J. She made no close friends and preferred solitary activities. Her school record was satisfactory and she entered the university. There were no heterosexual relationships at school or at college. The social worker assigned later to her case had attended classes with her at the university and noted that P. did not attend social functions there, did not relate to other students, or even converse with them, although she would be with the same group all day.

She was not strongly motivated to continue her education, apparently going to college largely because the foster parents wished it. She dropped out in the third year, and started clerical work, at which she remained until her marriage in 1937. Little is known of the courtship, but she became pregnant before the marriage and

had an abortion, allegedly arranged by her husband's mother, one month before the marriage. Her husband, a public school teacher, was greatly dominated by his mother, who disapproved of P. Her foster parents also opposed the marriage, particularly the foster father, who was incensed, and largely severed relations with P. Things went badly, with P. reported as extravagant, "secretive, sly, I could put no faith on her word," by her husband. Communication seems to have been extremely poor, as toward the end, he joined the air force, rented the house to tenants, and left without making arrangements for P. or even telling her of his plans. The complete rejection is obvious in his sloughing of the problem at the time she was so obviously sick, and wired for him to come. He divorced her during her hospitalization.

State in Hospital. On admission she was untidy, tearful and rather depressed. She was childish in manner. The form and content of her conversation were foolish at times, and seemed appropriate to a person of limited education, not one of university level. No frank delusions or hallucinations were noted, but she was irresponsible, of poor judgment, and lacked insight.

She continued in much the same fashion, handled her husband's successful divorce proceedings by denial, continually asking to be discharged to his care. Prior to her actual discharge in 1950, she was considered to exhibit impaired drive, vagueness of thought and circumstantiality, lack of insight and poor judgment. Her foster father, now reconciled with P. and divorced from his wife, wished to take care of her, and she was accordingly discharged. From his account she is managing well at home and is taking a business course.

The Foster Parents

The marriage of these people was an unhappy one. They married in 1911 and were finally divorced recently. The relationship was characterized by almost constant discord and hostility. On occasion, they would strike each other. There were repeated quarrels and recriminations. Their personalities will be considered separately.

The Foster Father. He was interviewed personally and found to be an elderly man with constant, extrapyramidal tremor of the hands. He was restless, affable, insensitive and facetious. His conversation was studded with repeated, tasteless, mild obsceni-

ties concerning his divorced wife; and most of his comments about her were derogatory. He maintained that from the beginning she was unfaithful to him with "Greeks, Wops, and men old enough to be her father." He blames his business reverses on the unsavory reputation she earned. She was a habitual liar, and frequently "hopped-up," i. e., under the influence of drugs.

He denied that there was any emotional disorder in the children in youth and felt they had adequate care in all respects. At the same time, he believed his ex-wife's "affairs" had been distressing to them. The information he gave was superficial and inconsistent, and he appeared unaware that his or his wife's behavior (other than her infidelity) might have been noxious. He attributed J.'s illness to anxiety stemming from concern about his wife's misdemeanors, and P.'s prolonged hospitalization. He felt P.'s illness resulted from her husband's brutality and neglect, and that there had been nothing wrong with P. that a few weeks in a rest home would not have fixed.

All in all he appeared to be an insensitive, autistic individual whose perceptions and evaluations were grossly distorted by his own needs. He had little capacity for empathy or understanding the needs of others.

The Foster Mother. She has remarried and is living several hundred miles away, but was reached by letter. Her husband's evaluation of her personality cannot be accepted, as it is doubtless greatly distorted. J.'s observations are regarded as reliable and are confirmed by her husband, from his acquaintance with the foster mother in recent years.

It is reasonably certain that she could not relate to the children in an affectionate fashion. She was obsessive, as indicated by her meticulous housekeeping and insistence that the girls cause no disorder in the house. She was strict, domineering and repressive. Sex was a tabooed subject, and she restricted their possible relationships with boys and their participation in sports and social activities. The frightening malevolence she bears J. is clearly shown in the following letter she wrote in reply to J.'s request for information regarding her real parents.

Dear J.

How guilty you must be and feel, when you were afraid to come and see me. You were always selfish and a trouble maker with a dirty tongue.

You have enjoyed telling all your friends, that you blame me for P

being in Essondale, Fran told her mother, so I know you have told others. You were always a hard cold person, and delighted in hurting people and causing trouble.

Your mother gave you away, why try to find her, you will be no comfort to her, just enjoy yourself, telling her what she was. You think your father a Jew, your mother never told who he was. Even Jews show some love, which you never have.

Your family will repay you with the same kindness, you are showing me, and be just as selfish.

I am sending your letter to Grandmother and she will enjoy it, for it just proves what my Father said about you.

She exemplifies in many respects the mothers of schizophrenic patients reported by Tietze.[9]

The Real Parents

Regrettably little information was obtained about the real parents. The infants' home where the children were adopted kept scanty records; and only the names of the mothers, the fact that they were unmarried, and the names and dates of admission and discharge of the babies were reported to the writer. In those days, the adoption act of the province where the home is located had not come into operation, and adoptions were very informal, poorly-controlled affairs. No adoption papers were available.

However this lack of information does not invalidate the thesis of this report. Bellak,[10] in his survey, notes the incidence of schizophrenia has been reported as varying between 0.33 and 2.9 per cent—at the most 3 in 100. Assuming for a moment that schizophrenia is largely genetically or organically determined, the chances of adopting a potentially schizophrenic child would be, at most, 3 in 100. The chances, then, of adopting two such children would be negligible.

Discussion

While the facts reported speak for themselves, it is desirable to clarify some of the factors involved. It is the writer's belief that the seeds of J.'s and P.'s psychoses were sown in the early years by the pathogenic interpersonal relationships established between the foster parents and children, and between the foster parents themselves. This led to marked sensitivity, insecurity and de-

tachment in both children, with inability to integrate warm, satisfying and secure relationships in later life.

The outstanding features seem to be these:

1. The almost constant hostility existing between the parents was threatening and anxiety-provoking.

2. Gross emotional deprivation was the lot of both children. Neither foster parent was capable of loving and satisfying their needs for affection.

3. These bleak relationships led to the development of isolated, sensitive, insecure, detached personalities, P. passive, J. more aggressive and better integrated. Both found close relationships too anxiety-provoking, and were unable to relate warmly to others and share satisfying emotional experience. The relationships later established with husbands were thwarting in that both girls married men whose primary ties were to their own families and who were, in consequence, incapable of relating fully to their wives. The prolonged frustrations in these marriages led eventually to schizophrenic disorders.

While little more can be said about P., and the data do not go much beyond a descriptive level, the additional information obtained about J. permits some speculation as to possible dynamics. As stated, she had always been an isolated, insecure person, with little capacity for communicating about, and sharing, meaningful emotional experience with others. She was always uncertain of, and concerned about, the attitudes of others to her. She became anxious readily. Despite these difficulties she was able to work and marry, managing fairly well until she became sick at the age of 31.

She married an undemonstrative man who was seldom affectionate and communicated poorly with her. She came to doubt his affection and felt, probably not unjustly, that he was more closely affiliated with his own family than with her. She had never felt fully accepted by this group, in contrast to her sister-in-law E., who, more aggressive socially, had attached herself closely to them.

It is likely that awareness of her adopted status was more traumatic than she realized, in that it may well have increased her sense of isolation, of not belonging, of difference. Perhaps the anxiety attack occurring as the children sang "Happy Birthday" had its determinant here. This knowledge, together with the grad-

ual attrition resulting from frustration of needs for tenderness, affection, belonging, in her marriage, and the resulting retaliative hostility, led to development of fantasies of a sexual nature, resulting in further anxiety and reduction in self-esteem. It will be recalled that she believed her obstetrician had implied she was a "sex pervert." From these sources her anxiety, depression, projections and distortions arose. The meaning of Jewishness to her was complex and seemed to include feelings of rejection, difference, inferiority and, on the basis of one quite illogical association, sexuality.

While this may be valid as far as it goes, a great deal remains unexplained. The meaning and extent of her sexual fantasies, for instance, are unknown, and could be obtained only by intensive psychotherapy which, for several reasons, was not practicable.

A brief reference to diagnosis should be made. There is little question that P.'s disorder approximates the conventional simple schizophrenic category. There may be some quarrel with the writer's attaching of the schizophrenic label to J. Many would prefer a diagnosis of paranoid state. As far as the writer is concerned it is not a significant distinction, in view of the continuum between paranoid states and cases of "clear-cut" paranoid schizophrenia.

Summary and Conclusions

1. Two cases of schizoid personality developing into schizophrenia are reported, in which the patients were foster sisters of different biological parents.

2. The pathogenic agents appear to have operated at the level of interpersonal relationships.

3. The likelihood of adopting two children potentially schizophrenic at birth is so negligible that it may be discounted.

4. The principal etiological factors were gross parental discord, gross emotional deprivation and the development in the children of schizoid personalities—unable to gain security and satisfactions in interpersonal relationships, becoming ill as a result of slow attrition from prolonged frustration of need in unsatisfying marriages.

5. These cases highlight the necessity for careful screening of prospective foster parents.

ACKNOWLEDGMENT

The writer wishes to thank Dr. A. L. Swanson, deputy medical superintendent, Crease Clinic and Provincial Mental Hospital, Essondale, B. C., for his assistance in collecting the data presented here.

The Seton Institute
6420 Reistertown Road
Baltimore 15, Md.

REFERENCES

1. Sullivan, H. S.: Conceptions of Modern Psychiatry. Republished by the William Alanson White Psychiatric Foundation. Washington, D. C. 1947.
2. Fromm-Reichmann, F.: Notes on the development of treatment of schizophrenia by psychoanalytic psychotherapy. Psychiatry, 11:263-273, 1948.
3. ——: Principles of Intensive Psychotherapy. University of Chicago Press. Chicago. 1950.
4. Cameron, N.: The Psychology of the Behavior Disorders. Houghton-Mifflin. Boston. 1947.
5. Shulman, A. J.: The etiology of schizophrenia. PSYCHIAT. QUART., 24:515-531, 1950.
6. Betz, B. J.: A study of tactics for resolving the autistic barrier in psychotherapy of the schizophrenic personality. Am. J. Psychiat., 104:267-273, 1947.
7. ——: Experiences in the psychotherapy of obsessive-schizophrenic personalities. So. Med. J., 39:249-256, 1946.
8. ——: Strategic conditions in the psychotherapy of persons with schizophrenia. Am. J. Psychiat., 107:203-215, 1950.
9. Tietze, T.: A study of mothers of schizophrenic patients Psychiatry, 12:55-65, 1949.
10. Bellak, L.: Dementia Præcox. Grune & Stratton. New York. 1948.

PSYCHOTHERAPY OF MANIC-DEPRESSIVE PATIENTS IN THE MANIC PHASE

BY NORMAN C. RINTZ, M. D., AND IRVING M. ROSEN, M. D.

The authors are presenting in this paper their early experiences with seven manic patients who were seen in psychotherapy during the past two and a half years at Boston (Mass.) State Hospital. The paper is an effort to show, simply, some avenues of approach to them and to indicate some surface issues that presumably were connected with their severe mood swings. The remarks will be restricted to observations made while the patients were in the manic phases of their illnesses. Because of the well-known tendency of these people to have remissions from their episodes without a doctor's active intervention, stress will be laid on those fluctuations in the intensity of the mania which seemed directly attributable to the therapeutic efforts. Following the case presentations, the needs shown by these particular patients will be summarized, and the difficulties that they presented listed. The cases, as will be apparent, have much in common, but each added something to the writers' appreciation of psychotherapy in this illness.

Case 1. A 23-year-old, unmarried woman, extremely hyperactive and destructive, talked in a rambling fashion about radio broadcasts; she had been sick for seven years with a circular manic-depressive psychosis. The mother is a hypercritical, cold woman, who divorced her husband when the patient was two and a half years old, then considered the daughter a handicap. She interfered with her daughter's every reasonable interest, and though the precipitating cause of the first manic episode is unknown, the mother's intrusion upon the girl's friendship with boys was a source of continued irritation to the patient. The therapist observed that this girl quieted down after five consecutive daily sessions of an hour each, and then became overactive only when he missed a day. The talk mainly concerned such immediate problems as the patient's fear that the doctor would be too busy or not interested enough to continue seeing her, or that she would again lose her man through her mother's or a nurse's intervention. After three months, she could tolerate the stress of absence from the therapist and went home, but continued therapy on an out-patient basis, seeing the doctor three times a week.

Recently, after two years, she recalled that these daily sessions early in her treatment made her feel like "the only one" and like an important figure on the ward. She said she had a need for her own man who would be understanding and strong enough to resist attempts of other women, or even of herself, to drive him away. When this need was satisfied, she could feel that she was a "real person." She did not remember that anything of what was said was of real importance. What meant most to her was that the therapist seemed understanding, and that he kept coming to see her.

Case 2. A 39-year-old, extremely active, talkative married woman had been sick for about a year. Her mother was a very fussy food faddist; her father, a righteous, influential minister. She was also married to a minister, but a "poorly-devoted" one who wished he could carry through his resolution to go into some other line of work. He had, just before the patient's breakdown, joined the denomination to which her father belonged. The therapist sat with this woman in daily hour sessions for three weeks, as with the preceding one, but she showed no slackening in hyperactivity.

Her ramblings became centered about an elderly, evangelical, rather austere minister who had been of help to her in the recent past. The therapist, taking the hint, became more firm and active in his approach. Within two days the patient lost much of her push of speech and activity. She did remain moderately overactive for a few more weeks, and flared up again when she heard that the therapist, unbeknown to her, had seen her husband. The recognition of her need to be considered an adult, and the inclusion of the patient in a subsequent conference between doctor and husband, preceded by only a few hours her return to her prepsychotic personality. The next day while enjoying a visit by her husband, she suddenly felt that something came between them, preventing her from loving him, and she became violently manic again. This time her talk indicated an almost complete preoccupation with fellatio as she screamed, "I want to eat meat but it's poisonous." Therapy with this patient was abruptly terminated three days later when she suffered a fatal asthmatic attack. (Before becoming manic she had been a long-time victim of asthma.)

Case 3. A 29-year-old, dramatic, seductive and witty, overactive, married woman had been sick continuously for six months.

Her mother is described as a constant worrier, with many somatic complaints; the father is a successful salesman whose hobby is amateur minstrel shows. The patient had been married for eight years before the manic attack. At this time her husband's business, which was unusually successful, was demanding practically all his time and thought. She had finished a course of insulin shock with some benefit and was hypomanic when first seen by the therapist. She lost this hypomania during the course of nine consecutive, daily, hourly sessions, and some months later told the doctor that the comforting elements in his approach had been his inclusion of her in his discussions with her husband and his reassurance that he did not intend to interfere with any of her reasonable interests. The therapist had a difficult time to prevent himself from becoming involved in her subtle arguments and in her witty stories, but he had had the advantage of observing the discomfort of members of the family who did become enmeshed in these productions. Further treatment was not attempted at this time.

After a year of apparently satisfactory adjustment at home, marred by a two-month-long episode of mild depression, this patient began to get overexcited again, and therapy had to be resumed. She now had many complaints. She said that her husband was not decisive enough, that he preferred his mother, treated her like a child, and did not show enough appreciation of her feelings and struggles. As the therapist had begun to appreciate these issues, the husband made an attempt to treat her as an adult woman, and she quieted down. Then, suddenly, she went into a frenzied manic episode. Among the puns and sound associations, one made out that things had begun to go too well for her, and that the therapist was too kind. She screamed about hot pipes, coconuts, things in her mouth, choking sensations, a split of her body into right and left, her right leg feeling bigger than her left, and was very dramatic, exhibitionistic, teasing, and seductive.

In daily sessions, attempts were made to reassure her concerning her fantasies. This endeavor had not the slightest effect on her mania. After six weeks, the therapist, encouraged by a recent report[1] from Chestnut Lodge stating that a manic sometimes does well on fewer meetings a week, decreased the number of sessions from an hour daily to a half-hour three times a week. The patient evidenced no distress at this seeming lack of interest. In fact,

after two of these less frequent visits, her speech became much more relevant, and she began to ask for visitors from home. At the same time she showed interest in considering the issues responsible for her confusion and hyperactivity. The main issue was her anxiety at feeling too close to the therapist, which hurt as much or more than the trauma of rejection.

Case 4. This case was that of a 45-year-old, clinging, good-natured but annoying, manic widow, trying too hard to help others. She has had many episodes in the past five years, each lasting two or three months, with about the same quiet intervals. This patient was seen irregularly in therapy but showed quick fluctuations in the intensity of her mania. She could be relieved by recognizing her need to help others on her own terms; otherwise she felt that she was being "used," that she was being treated as an infant, and that her independence was being threatened. It was this type of trauma at the hands of her sister and grown-up children that had preceded her many manic episodes. Unfortunately, she had not the confidence to refuse impositions upon her good nature. Her push of speech increased if she detected any note of condescension in the voice of the therapist.

Case 5. This patient was a 19-year-old, overactive, demanding, seductive, somewhat destructive, unmarried girl who had had a manic episode at 16, lasting 16 months, and had just returned to the hospital with her second attack at the age of 19. Her mother is described as hypercritical and prone to illness, especially when anyone in the family became angry with her. The father is an abusive, yet seductive, alcoholic. Interested listening daily for an hour on the part of the therapist seemed to quiet the patient, but she continued to act out rather dangerously on the wards by swallowing needles and getting into fights with other patients. Her acting out was worse when the therapist did not see her over week-ends.

Setting firm limits to this behavior and transferring her to a disturbed ward made her feel more comfortable and had the effect of converting her acting out into talking out. It developed that she was punishing herself for fantasies of taking her father away from her mother and having his baby. She had the feeling that both parents considered her bad, and she made inordinate demands on them, thereby provoking hostility, punishment, and rejection. She had turned to her grandmother, who had lived with

the family since the patient was seven, for support. It was three weeks after this grandmother's re-marriage that the patient had had her second attack. She was greatly improved in the hospital three months after the start of therapy, but it was six more months before she could remain at home without becoming excited and demanding.

Case 6. This patient was a 41-year-old, argumentative, assaultive, very loud, somewhat paranoid spinster, chronically manic and hospitalized for the past five years. Her illness appeared to have been precipitated by the unexpected marriage of a much younger sister whom the patient had been devotedly mothering and supporting. She improved slightly during two months of therapy, consisting of four to five hourly sessions weekly. The therapist listened carefully as she poured out fantasies of being raped, of her belly bursting, of swallowing poisonous objects. An immediate problem began to crystallize, namely, that she wished to be independent and earn her own way. Her confinement in the hospital made her feel dependent and like a "kept woman." When the doctor indicated that he had grasped this issue and that he would allow her to work as soon as she was able, her push of speech and restlessness subsided within two days, and she was placed on a convalescent ward with permission to work in the greenhouse. She remains slightly overactive and continues in therapy.

Case 7. This patient was a 30-year-old man, ill "off and on" for 15 years, and in his present overtalkative, exhibitionistic state for a year. His first manic episode, according to his mother, followed a blow on the head when he was only 16, but there was never any corroborating evidence of organic brain damage. The mother appeared to be a capable and warm person, although too easy-going. No interest in the patient was ever evidenced by the father. He was an engineer and quite bookish, but his son in his nonpsychotic intervals showed a strong aversion for all things technical, including technical books, and was severely handicapped when it became necessary for him to decide on a vocation.

This patient, with daily, hour-long sessions, showed no sudden decrease in mania, but rather a very gradual quieting down over a period of five months. He subjected the therapist to a long series of "tests," after each of which he would appear slightly improved. He tried to shock and disturb in many ways, he masturbated openly, he indulged in talk of obscenities, recounting the history

of his perversions; and he threatened, mocked, and swore. He also acted out many hero fantasies, being in turn a ball player, singer, dancer, actor, minister, lawyer, and psychiatrist. About all the therapist did was to talk baseball with him and remain unfrightened by his obscenities and threats. Occasionally he pointed out to him how homosexual and autoerotic activities interfered with his striving for masculinity.

Discussion

Considering these cases, one finds that the patients displayed only a small number of predominant needs. When these were recognized and, if reasonable, acted upon, their manic symptoms tended to subside, sometimes very quickly (though this gratification soon brought to the fore a new set of problems). The needs did vary somewhat from patient to patient; this prevents generalization, because each case added new insights. There was the need to receive frequent evidence of constant acceptance (especially Cases 1, 5 and 7) despite a severe testing of the therapist. Some of the women patients indicated in their talk their need to be treated by a particular kind of person, possibly a father ideal. The first woman wanted a strong but kindly therapist; the second wanted a firm, active, austere one (her father is a minister); the third wanted a capable but jolly person who would be much concerned over her (her father is a salesman and showman).

Relapses, after an apparently workable relationship was established, were concerned, not so much with these patients' desires for their object, as with their fears of coming too close to this object. Tender feelings were associated with anxiety based upon infantile fantasies of sexual and aggressive nature. At this time, it was particularly important for the therapist to appreciate the nature and intensity of the patients' anxiety and to take an active supportive role by varying the number and length of sessions according to the patients' needs.

Although these patients had marked dependent needs they appeared at the same time extremely proud and sensitive, especially hating any implication that they were to be treated as children or that they were dependent. They flared up when left out of doctors' discussions with their relatives, or when forced, without being consulted, into activities, even into ones they enjoyed. They were deeply ashamed of being a burden and of the "stigma" of the men-

tal hospital. Three of the patients after emerging from the psychotic state, expressed guilt and shame because of their uninhibited behavior, and subsequently evidenced rigid moralistic behavior. Some of them needed acceptance for their burning desire to help others, some for their exhibitionistic interests, such as acting or radio broadcasting.

It seemed particularly unfortunate that these proud persons, in their over-eagerness to express themselves, were forced out of direct expression into extreme circumlocution and into sound or clang associations so that they prevented the listener from grasping their point, or indeed from waiting until they could arrive at it. They needed someone to listen patiently for days or weeks while they expressed only one immediate problem, although in the meantime they touched on many related or previously unconscious ones. One manic woman (Case 4), in attempting to criticize a doctor for slighting her, brought in her feeling of inferiority because of her race, her experiences in mental hospitals, the ingratitude of her children, her many gifts to her relatives, and the high reputation of her brother, before coming close to the present reason for her tirade.

It should be mentioned that the therapist was expected by the manic not only to have some understanding of his needs but also to appreciate the depth and intensity of these needs, and of his hurts and disappointments.

Finally, one should consider the manic's need for limit-setting on the part of the therapist. Appropriate firmness was of course necessary to stop dangerous acting out (especially Case 5) or persistent unreasonable demands, and to protect the doctor against the physically clinging manic or the occasionally assaultive one. In addition to being safer and feeling protected against his own impulses, the patient had an indication of the doctor's interest and concern. Furthermore, the patient thus received an opportunity to identify with the therapist's mature behavior in the anxiety-producing situation.

The writers are aware that the discussion so far seems oriented more toward the needs of the patient and how the doctor can meet them than toward the working out of problems arising out of frustration of these needs. What one expects from these patients must be tempered by appreciation of their intolerable anxiety. As the anxiety diminishes, one can begin to expect them to deal

with frustration, and inquiry can be made into the genesis of the anxiety. Then they can gradually be helped to work out their emotional problems as they arise in their current interpersonal relationships in hospital, home, and job.

Despite their great needs for dependent gratification, the manics reported here had a marked tendency to trap the therapist into retaliation or rejection, and their testing and provoking were carried on with much ingenuity and with few holds barred. One felt, at the same time, that they were trying in various ways to throw the therapist off balance and out of control of the therapeutic situation. They warded the therapist off with innumerable words which seemed connected only by their sounds or by their possibilities for punning; or with an overwhelming show of brilliance and irrelevant knowledge. They provoked him with their wit, sarcasm, and mockery; imitated his every movement and word; and analyzed his emotional life too keenly. They worried him by forgetting to eat, by acting out and running away, or by threatening to go into a depression. They confused him with stories they thought he wanted to hear. They invited his contempt and disgust by excreting or masturbating openly. They refused to get well if success was too important to him, and kept him on edge by their quick changes from love to hate. They sometimes kept him laughing unwillingly with their comic or dramatic talent, or frightened him with threats, or made strong attempts to seduce him, and they drained his supplies of affection by persistent unreasonable demands, by clinging, by minding his business with too much helpfulness, or by a constant boastful and domineering attitude.

The manic attack as a whole seemed to serve many purposes for the patients, in addition to that of embarrassing their "important objects." Unwittingly, they used this violent illness to force their objects to recognize their problems and to do something constructive about them—for example, some wanted more recognition from spouse, mother, sisters, or doctor. The mania further served as a screen for the acting out of previously forbidden desires, which now became too strong to keep away from motor expression. Sometimes one felt that the patients were showing off their wares in an attempt to gain an object, but were anxious because they already expected the attempt to fail. The woman manic seemed also to give the illusion of masculine activity or of the activity of the prostitute—as opposed to feminine passivity, which was consid-

ered dangerous because it was tied up with many dangerous fantasies as already mentioned. Two of the patients themselves used the adjectives masculine and feminine in connection with the amounts of their activity. Activity was desired also to cover strong dependency needs, to give the illusion of independence or proud insensitivity to past or expected rejections, and to ward off kindness, gifts or personal closeness which the patients felt they had not the resources to repay. The defiant and the provocative aspects of their behavior had the effect of bringing punishment and repeated rejection upon themselves; and, in therapy, seemed designed to create a devalued therapist upon whom they felt justified in venting their spite.

The writers speculate that the push of speech functioned as a smoke screen for the patients' humiliating demands for assistance, as an overwhelming attack on the listeners' mentality, as a spewing out of disgusting objects, and as a sheer pleasure in the use of the mouth.

Because of the impact of the manic's attack on the personality of his therapist, the latter found that outside support and personal inventory-taking were of value to help him maintain flexibility in attitude, without being forced into retaliation or rejection. The writers have, in the case descriptions, oversimplified the events during treatment, by leaving out a detailed account of the difficulties of the countertransference. For example, in merely attempting to reduce the weekly number of interviews from six to three in one of these cases, the therapist became aware of feelings of therapeutic haste in himself, stemming in part from his desire to impress his colleagues, the patient, and her relatives; and these feelings were all the more persistent because they covered a growing hostility toward the patient for not getting better. The subject of countertransference in relation to work with psychotics was explored by Mann, Menzer and Standish[2] at the 1949 American Psychiatric Association meeting. In the present paper, the writers hope merely that they have shown some possibilities in a psychotherapeutic approach to the manic patient that warrant continued investigation.

Summary

Experiences with seven manic patients are described, with an attempt to study how the therapist may have effected changes in the

intensity of their manias. Important issues centered around rejection by the therapist, or fears of intimacy with him. The patients were extremely sensitive to implications that they were inferior, dependent, or childish. They required the therapist to maintain flexibility in his activity, and to respect their reasonable interests, such as helpfulness to other people or exhibitionistic pursuits.

Maintenance of a non-retaliatory and non-rejecting, yet at times limit-setting, attitude was necessary, though the testing out of the therapist by the patients was severe.

Boston State Hospital
Boston, Mass.

REFERENCES

1. Fromm-Reichmann, F.: Intensive psychotherapy of manic-depressives. Confina Neurologica, IX, 1949.
2. Mann, J.; Menzer, D.; and Standish, C.: Psychotherapy of psychosis; some attitudes in the therapist influencing the course of treatment. Psychiatry, XIII, 17-23, 1950.

BIBLIOGRAPHY

Abraham, K.: Mania. In: Selected Papers. Hogarth Press. 1929.

Dooley, L.: A psychoanalytic study of manic-depressive psychoses. Psychoan. Rev., XIII; 38, 1921.

English, O. S.: Observations of trends in manic-depressive psychoses. Psychiatry, XII:125, 1949.

Fenchel, O.: Psychoanalytic Theory of the Neuroses. Pp. 4-7-411. Norton. 1945.

Freud, S.: Mourning and Melancholia. Coll. Papers, Vol. IV.

SOME NOTES ON THE PSYCHOTHERAPY OF SCHIZOPHRENIA

BY MAURICE R. GREEN, M. D.

It is useful to review what is meant by these words—psychotherapy and schizophrenia. In regard to a definition of psychotherapy Robert Knight said, "In the last analysis, there is only one Psychotherapy, with many techniques. This one psychotherapy must rest on a basic science of Dynamic Psychology, and those techniques should be used which are clinically indicated for each individual patient . . . certain appropriate techniques for the initial stages, and others later as a continuous clinical evaluation proceeds—paripassu with therapy. . . . It is important to recognize that techniques as such are hardly separable from the individual who uses them. *Psychotherapy* is an enormously complex intercommunication and emotional interaction between two individuals, one of whom seeks help from the other."[1]

This therapeutic relationship differs from other such emotional interactions by reason of the therapist's limited role as therapist and his, one hopes, superior awareness, and wider experience of himself as a human being. The schizophrenic patient, in contrast, scarcely experiences himself as a human.

Schizophrenia or its older synonym, dementia præcox, is an example of a relatively poorly-defined medical concept. Bellak, Fenichel and many others agree that schizophrenia *is not* a disease entity but rather embraces a whole group of disease syndromes. These range from a single transitory psychotic episode to a lifelong psychosis of indifference and apathy beginning in childhood and adolescence.[2] Bellak, Sullivan and others suggest that the term schizophrenia be reserved for a psychogenic psychosis, characterized by a more or less acute onset and a more often benign course; the term dementia præcox would then be reserved for the classical Kraepelinian psychosis characterized by an insidious, progressive, usually irreversible, course.

Eugen Bleuler, who introduced the term schizophrenia, defined it as a "group of *psychoses* whose course is at times chronic, at times marked by intermittent attacks, and which can stop or retrograde at any stage, but does not permit a full restitutio ad integrum. The disease is characterized by a specific type of alteration of thinking, feeling and relation to the external world which

appears no where else in this fashion. In every case we are confronted with a more or less clear-cut splitting of the psychic functions. If the disease is marked, the personality loses its unity; at different times different psychic complexes seems to represent the personality."[3]

Sullivan described this further, "in schizophrenic states, on the other hand, a state of conflict has as it were been universalized, the conflict-provoking tendency systems being accorded independent personality with power greater than that of the self. Instead of anxiety, there is fear and often terror. So far as the self functions, the patient is engaged in (regressive) magic operations in an attempt to protect himself, to regain some measure of security in the face of mighty threat, portents and performances in a world that has become wholly irrational and incomprehensible."[4]

By the term schizophrenia then, the present writer refers to a disorder of living in which the patient has experienced himself as profoundly worthless, helpless and completely isolated, in a violently, immediately-threatening world; and he has become preoccupied with magical gestures, private reveries and hallucinations as part of his struggle to survive and perhaps to eventually realize himself as a human being among other human beings. He experiences other individuals as potentially threatening to the extent of arousing intensely fearful rage reactions, or as potentially lifesaving to the extent of his becoming extremely dependent. He is, therefore, extremely and intensely sensitive to the reactions of others.

In this very precarious situation, the individual manifests, as aspects of his struggle, certain kinds of patterns which may become more or less predominant in the course of time. One of the most characteristic is the inhibition of perceptual response to the outside world and to people around him. In its most profound form, this has been described as the catatonic stupor, in which the individual, like the proverbial possum, pretends that he isn't there. In a less profound degree, this characterizes what has been called the simple schizophrenic. In this pattern, the individual functions as a kind of mechanical doll—dull, apathetic, blunt, and more or less obedient to command.

Another frequent defensive activity is to substitute hatred for affection as the schizophrenic's goal. He thus achieves aware-

ness of himself as an exceptional but persecuted individual. This describes the hostile, arrogant, paranoid picture. To the extent that the individual is successful in functioning with this pattern, he will establish only mutually-hateful relationships. This kind of hostile defensive activity is also described to some extent by the various types of negativism.

The individual who manifests the pattern of behavior called hebephrenic avoids all semblances of intimacy with anyone because his peace of mind is seriously disturbed by even the most rudimentary relationship with any real person. By bizarre gestures and expressions, one of the most characteristic of which is a peculiar kind of giggling and smiling, he interrupts any attempt to ascertain his needs, interests or other private processes.

The views set forth here on the therapy of schizophrenia have previously been expressed by Harry Stack Sullivan and Frieda Fromm-Reichmann. In the treatment of these patients, one must first of all have a genuine desire to help them. It must not be assumed that, because these individuals frequently inhibit their perceptual responses to a great degree, they are not extremely perceptive of our behavior and feelings toward them. This implies disagreement with the patient's extremely discouraging and pessimistic statements about his potentialities. This disagreement must be communicated verbally even though the patient severely distrusts all verbal expressions. It must also be communicated by intonation, gesture, postural tensions, and the constructive processes of arriving with the patient at an understanding of the problems that he has had with the important people in his life, problems which have led to his present difficulties.

By this, the writer does not mean to refer to the kind of guilty, anxious, oversolicitous, overprotective care that so many of these patients have experienced from severely anxious and distraught mothers. Often these mothers may have been rejecting because of their own desperate needs. Acceptance of, and permissiveness toward, a regressive, infantile part of the patient's personality should therefore be blended with respect and understanding, according to the patient's chronological age. This can be shown, for example, in responding to hallucinatory or delusional manifestations in terms of registering absence of agreement rather than dis-

agreement. For example, one might state, "I do not hear or see what you hear or see. Let us investigate this." In another instance, when a patient is behaving in a very infantile fashion, one might say, "Your acts of spitting, hitting your head against the wall, peeing, etc., do not tell me very much. Maybe you can tell me in words what you want to say." Sometimes, this infantile acting-out has to be accepted until it is replaced by the patient's regained ability for verbal communication.[5] Such acceptance is also governed by the limitations of the environmental situation or institution.

The therapist must accept from the beginning the probability of misunderstanding the reactions of the patient and being misunderstood by him. By and large, the progress of the patient will not be interrupted by such misunderstanding on the part of the therapist if the misunderstanding happens in the spirit of therapeutic humility and not in the spirit of any type of overbearing personal therapeutic ambition. It is frequently helpful to ask the patient to clarify something that the therapist doesn't understand. It is no reflection on professional competence to communicate to the patient the difficulty in understanding what he is trying to say.

Some of the personal difficulties that frequently have arisen in the treatment of these patients are:[6]

1. The frustration of the individual psychiatrist who sees himself as carrying out a magical, noble mission.

2. The psychiatrist who is hurt or paralyzed by the patient's withdrawal because he experiences it as personally directed at him.

3. The psychiatrist who feels resentment and anger toward the patient because he feels the patient has humiliated him. This may occur because he experiences the difficulty in understanding the patient's communications as a reflection on his own intelligence.

4. The psychiatrist who may become overzealous and encounter violence. Violence should always be avoided for the protection of the psychiatrist, as well as for the protection of the patient's self-respect.

5. The provoking of considerable anxiety in the psychiatrist by the insight of an extremely perceptive patient into the psychiatrist's personal difficulties.

6. The limiting of the psychiatrist by narrow conventional attitudes and prejudices. The patient's sense of basic human values will then prevent any extensively useful therapeutic relationship from developing.

Sullivan has described several useful pre-conceptions that underlie the first interview with the patient.[7]

1. The patient is a stranger and is to be treated as a stranger. There is no reason for presuming any particularly friendly or unfriendly attitude.

2. Questioning follows the patient's trends of thought and does not contradict any of them. For example, if a patient states that people are staring at him, it is wrong to say to him, "Why do you feel people are staring at you?" or "What makes you think people are staring at you?" These questions imply the psychiatrist's contradiction of what the patient has stated to be true. The correct response would be, "Why are people staring at you?"

3. The questioning proceeds more or less indirectly, with an emphasis on understanding the nuances of the patient's statements rather than their explicit content.

4. The psychiatrist has a general dynamic view with a constant sensitiveness to the continuous changes of tension.

5. The most important preconception underlying the first interview and in fact all interviews with any patient in psychotherapy is the assumption that every human being is much more simply human than unique, and that no matter what ails the patient, he is mostly a person like the psychiatrist.

SUMMARY

This paraphrase of the work of Fromm-Reichmann and Sullivan is offered in the framework of definitions of both psychotherapy and schizophrenia. It is hoped that it will be useful to students of these important contributors, and to the busy doctors in both offices and hospitals who must deal with these problems.

14 East 80th Street
New York 21, N. Y.

REFERENCES

1. Knight, Robert: Critique of the present status of the psychotherapies. Bull. N. Y. Acad. Med., 2:25, 100-114, February 1949.
2. Bellak, Leopold: Dementia Præcox. Grune & Stratton. New York. 1948.
3. Bleuler, Eugen: Dementia Præcox or the Group of Schizophrenias. International Universities Press. New York. 1950.
4. Sullivan, Harry Stack: Conceptions of Modern Psychiatry. William A. White Psychiatric Foundation. Washington, D. C. 1947.
5. Fromm-Reichmann, Frieda: Principles of Intensive Psychotherapy. University of Chicago Press. Chicago. 1950.
6. ——: Notes on the development of treatment of schizophrenia by psychoanalytic psychotherapy. Psychiatry, 2:263-273, 1948.
7. Sullivan, Harry Stack: Ibid.

PSYCHIC DISTURBANCES IN TYPHUS FEVER*

BY OSKAR GUTTMANN, M. D.

The pathogenesis in cases of correlation between the acute infectious diseases and varied concommitant psychic syndromes is still completely unknown. Kraepelin made an attempt to attribute to every acute specific disease a specific psychic clinical picture. Kraft-Ebing and Stertz believed that the mental disorders might be caused by general circulatory and nutritive disturbances of the central nervous system. Adolf Meyer in this country did not admit to a systematic description of special psychic disturbances in the course of infectious diseases; but he spoke of behavior abnormalities, which, on the basis of disorders in the nutritional support of the central nervous system, must be attributed to an individual psychobiological reaction of the personality. He called this a "dysergastic reaction," which is a generalized response of the individual to toxic, infectious, metabolic, circulatory and traumatic disturbances. All the variations of the psychic syndrome which might appear in response to such disorders form, in fact, a variable general reaction which is colored in every case by the individual intellectual endowment and temperament, emotional predisposition, experiences, age, sex, previous mental health and environmental circumstances. The so-called "exogenous psychosis," "toxic infectious psychosis," and "infective-exhaustive psychosis," all represent this dysergastic reaction.

Spielmeyer and Dawidowsky attempted to make use of the histopathological fundamentals to explain the psychic disturbances of typhus fever. They came to the conclusion that in this disease the pathological findings might be similar to those of a meningo-encephalitis. Similar findings were reported by Harris, Peterson, et al., and by Binford and Ecker.

All the pathological findings of typhus fever include several lesions in common: generalized inflammations of capillaries and the small vessels, resulting in endangiitis; thromboangiitis of small and large vessels, including veins; degenerative clouding and necrosis of the intima of the vessels; perivascular and interstitial mononuclear infiltrations, which are the so-called "typhus nodules" of Fränkel; and small infarctions scattered throughout. The gen-

*Read at the upstate interhospital conference of the New York State Department of Mental Hygiene, Syracuse Psychopathic Hospital, Syracuse, N. Y., April 17, 1951.

eral opinion held is, that all these alterations might favor development of the neuropsychic disorders, but cannot explain them completely.

Bonhöffer described the exogenous psychoses in his monograph and tried to emphasize the individual character of each; but he did not admit the special classification of Kraepelin. Bonhöffer attempted to explain the relation between acute infection and psychosis by his theory of an "etiological intermediate toxic factor." Kehrer suggested a constitutional deficiency of the defense mechanism of the central nervous system. Somogyi and Rath found significant roles by both exogenous and endogenous factors in the production of symptomatic psychoses. They believed that, in such psychoses, with such patients a constitutional weakness exists in the mesodermal components of the central nervous system—in which case the toxins might penetrate the mesodermal barrier with ease—and that, in the formation of an endogenous psychosis, there might be important and hereditarily conditioned elective degeneration of the ectodermal components of the central nervous system.

In almost all acute infectious diseases, psychic syndromes of different degrees are observed. Although there are no specific disturbances in an infectious disease, it is still possible to note, in some instances, psychic syndromes which occur repeatedly in the same disease regardless of the personality. Instances are the depressions in influenza or the exhaustive stupor in cholera.

The writer's present observations are made on the basis of 430 cases of louse-borne typhus fever which were seen during two great epidemics in eastern Europe during the years of 1941 and 1945. The description of the psychic disturbances is supported by the author's own experience while infected with the disease. Insofar as there is a considerable variety of mental disorders noted, it would seem advisable to follow them from the prodromal stage of the disease through its height and decrudescense, into convalescence and even beyond.

Although the prodromal stage of typhus is not one of fixed characteristics, psychic disturbances are very often noted during the first days. The patients are still able to work but feel marked fatigue; complaining of headaches, which last throughout the whole course of the disease; aches in the back and neck; general muscular aches; pain in the eyes and fever. Soon afterward, the slight clouding of the sensorium that is characteristic of

the exogenous psychosis begins. The patients begin to exhibit a disturbance between the sensory excitations of the environment and the activity of the cortex—which normally determine the co-ordinated function of "consciousness." This process leads to a dissociation of the awareness of the bodily self and of environment, and, according to Martin, to a *disorder of the "body and mind" image.* Marked psychic fatigue, decreased recollection power, decreased concentration, perception and apperception are the consequences of this disturbance. The patients gradually become prostrated physically, and, with this, develop apathy and indifference. As a rule during the first week it is possible to notice marked drowsiness, which causes the patient to be in a dazy, dream-like state. Stockert found that, in this condition as in encephalitis lethargica, it is possible to induce real sleep through hypnotic procedures. At this stage, Munk observed signs of catalepsy: Passively-induced bodily positions are maintained as in catatonics. Muscular rigidity at the beginning of the disease, which is obvious during passive movements, gives presumptive evidence of involvement of the extra-pyramidal system. At the start of the disease, perseveration and a tendency to stereotypical movements are seen. Patients also may present disturbances of affect, mostly exhibiting excitement, anger, depression, psychomotor hyperactivity or the opposite of it, and a tendency to cry. The majority show anxiety, fear, and apprehension which may be considered common symptoms of Meyer's dysergastic reaction, independent perhaps of the existing special clinical picture.

In severe cases, early symptoms include a clouding of the consciousness which is so intense that there is a marked disturbance in the awareness of the surroundings; there is restlessness, as well as incoherence of ideation. In these cases, the patient lies on his back, he cannot sit up any more and cannot even be turned on his side. These patients rapidly develop stupor and often exhibit a dramatic variability of stupor and delirium. In moderate clouding of the sensorium, the characteristic sign is that the patient can be recalled to an awareness of his surroundings through external stimuli, as calling him several times or shaking him. This does not occur in the severe cases.

The severe and distressing headache which ushers in typhus fever is soon accompanied by a tinnitus which gave the author personally the impression that gnomes were sawing and hammering

with many instruments in his inner ear. Giljarowsky noticed similar phenomena in his patients; and he explained this illusional sensorial disturbance as a deep reversible disorder in the neuropsychic sphere, including the sensorial center and the acoustic nerve. Similar symptoms are described by Bonhöffer in connection with disturbances in the labyrinth and semicircular canals. Patients in this stage have the impression that they are flying in planes, sailing in ships, having accidents and collisions, having experiences of earthquakes or falling into deep abysses. Disturbances of the proprioceptive sensations belong to the same category of organic neurosensorial disorders. Among these, Giljarowsky described the so-called *"double image madness,"* which the present author himself experienced. It is a false impression that someone else is lying beside the patient in the bed, or one that a lower limb may represent another person, or an extremity appear to be two extremities, or there may be two heads. Whether this disturbance of the body image is due to pathological changes in the hypothalamus or in the proprioceptive afferent tracts, or in the upper brain stem, or, finally, in the cerebral cortex, remains an unsolved problem. Maybe the postcentral gyrus, the anatomical substratum of the postural sense, is also impaired.

Toward the end of the first week of the disease, at approximately the time when the rash appears, the psychiatric clinical picture becomes one of the frank delirium. The passage from a simple clouding of the sensorium to a delirium was felt by the author himself to be a change from a distressful tension—which was caused by an unconscious attempt to maintain contact with the surroundings—to a pseudo-euphoric comfortable dream-like state.

The old definition of *"delirium"* is synonomous with that of "acute delirium" described by Bianchi. In this state, there was understood to be an intense impairment of the sensorium caused by a serious general affection of the cerebral cortex, with predominance of hallucinations and a rapidly increasing dissolution of the psychic personality—this soon reaching its height and being characterized by intense motor agitation, by clouding and abolition of consciousness, by muscular contractions up to real convulsive seizures, by tendency to collapse and even by fatal issue.

The subdivision of the deliria by Kraepelin into initial deliria, fever deliria, collapse deliria, is no longer recognized. Bonhöffer expressed the opinion that the deliria are symptomatic

phenomena. The general characteristics of the delirium are, in addition to the impairment of consciousness, as already described, a dream-like state in which illusions, hallucinations, and delusions as well, are significant—a special affective state which is generally adequate for the content of the delirium—and extreme anxiety. The content of the delirium is based upon the personality of the patient, his intellectual background, his most impressive experiences in life, and the impression made by the surroundings.

Martinet calls "*oneiric delirium*" a special delirious reaction with an overly elaborated, partially coherent, dream-like, rich, symbolized content. Simple delirium does not have such a fairy-like quality. The author himself experienced such an "oneiric delirium," in which he re-lived in picture-like sequence, specific, impressive events of his life.

In the delirious reaction, Bleuler often saw manic syndromes of short duration, with deep clouding of the sensorium. Sadler finds the opposite: that the delirious mania, supervening after a period of exhilaration, appears as a rule in cases of mild delirium. These patients show hallucinations; complete disorientation; superabundent, incoherent talking; hyperactivity, which has to be controlled by restraint; a tendency to complete physical exhaustion if not controlled, and delusions of suspicion.

Characteristic features of the delirium include hallucinations, illusions, and, more rarely, delusions. The illusions are more frequent in the second form of the confusion, which may be called "*amentia*" and which appears at the height of the disease. There is an opinion that blurring of perception in connection with vegetative irritations, or unknown stimulation of various central sensorial spheres, induces the hallucinosis. The hallucinations are generally visual. They may be auditory but are rarely in the sphere of taste and smell. Hallucinations seem to be provoked at times by irritations of the special sphere. Liebmann, Bonhöffer and Hoch provoked hallucinosis in delirious patients by pressure of thumb on eye ball.

The content of the hallucinations is varied: scenes in connection with friends, parents, neighbors and people of the outside world; various scenes with wild and domestic animals; ghosts or mythological figures; peculiar flowers, plants and people; witches, dwarfs, naked women, and, more rarely, obscene scenes. The affective nature of these is tinted by the individual's personality.

Patients may exhibit fear and anger, lively talking and restlessness, or cheerfulness. Wolff, Curran and Desmond, express the opinion that the hallucinosis is loosely organized and sketchy; this observation would fit the simple fever delirium, but not the systematized oneiric delirium, which can last without interruption for several days, and from which the patient usually cannot be recalled. Deep oneiric delirium can occur during the day, as well as during the night, and can leave a deep impression upon the patient for a long time. In rare cases, the oneiric delirium can pass into a postinfectious psychosis, sometimes called "residual insanity." This means that the infectious disease was only a precipitating factor in an already present dormant psychosis. The delirious reactions sometimes reveal—but less often—delusions of a paranoid character. There seems to be a connection between delusions and depth of impairment of consciousness; and it apparently requires a very severe alteration of the personality structure to allow the formation of delusions.

In 25 cases, in which delirium was present, the writer observed complications at the height of the disease which impressed him as possibly being due to serious disturbances of the correlation between endocrine and vegetative systems. The somatic disturbances ran a parallel course with the acute onset of the deepening delirium, which threatened to lead to a severe amentia. The prompt institution of specific therapeutic measures produced an improvement of the delirium and of the psychosis, and in several cases resulted in partial recovery in the entire clinical picture.

In 15 of the 25 cases just noted, there was sudden occurrence of the following symptoms: acute weakness, tremor all over the body, profuse sweating, bradycardia, mydriasis, slight meningism and hyperreflexia. The syndrome impressed the writer as probably being due to hypoglycemia. The blood sugar could not be determined because of technical difficulties, and the hunger of the hypoglycemic would have been obscured by the deep clouding of consciousness. The repeated intravenous administration of 33 per cent glucose solution and the oral administration of concentrated sugar solutions caused the disappearance of the physical signs and brought marked alleviation of the mental symptoms.

In the remaining 10 of these 25 cases with delirium, mostly young individuals, in whom there was no evidence of previous cardiovascular disease, there were observed at the height of the dis-

ease, simultaneously with the delirium, certain shock-like conditions, consisting of marked lowering of the blood pressure, sudden decrease of the fever, small pulse and cyanosis, especially of the hands and feet. The blood pressure ranged from a systolic of 80 to 70 mm. Hg. to an inaudible diastolic. The suspicion that the syndrome was comparable to that which is often seen in an acute infectious disease, was supported by the administration of cortisone, adrenalin, vitamin C, 33 per cent glucose solution and analeptics. Marked improvement of both mental and physical symptoms followed.

Between the first and second week of typhus, the writer observed, in addition to the deliria, "*trance-like*" conditions, which had a striking analogy to the narcoleptic states of hysterics or epileptics. The patients presented relaxed muscles, analogous to hysteric sleep; anesthesia of the skin; abolition of the reflexes; and complete psychic dissociation. At this point it should be emphasized that in catalepsy the muscles present marked rigidity.

At times the patient presents suddenly, either extreme anxiety or extreme apprehension, being wild and aggressive with homicidal and suicidal impulses, having the tendency to jump out of bed, and expressing fantastic images of fear, being completely confused, and having very fleeting hallucinations. This psychomotor restlessness may last several days and may be sudden in onset or more gradual, being preceded by a deepening state of confusion. It may also last only a few hours; occasionally it ends in epileptiform seizures, or may pass into a stuporous state. As this trance-like state subsides, the patient still is unable to recollect; his associations are poor; he presents a tendency to perseverate, and exhibits a shallow affect as a rule, or a certain degree of excitability. Stereotyped behavior, extrapyramidal disturbances with catatonic features, and paralyses of the extremities are observed in some cases after such psychic disturbances. In this stage, disturbances of speech are noted frequently. Bonhöffer saw, in his patients, a motor aphasia lasting for days, followed by indistinct roaring. Stockert attributed such disturbances of speech to extrapyramidal involvement, citing in support of this opinion the inability to protrude and replace the tongue slowly. The patients, as a rule, are unable to stick out their tongues, or do so with great difficulty. If they can do so at all, the tongue is mostly propelled forward quickly on command, returning to the oral cavity with a

resounding snap, similar to that heard in patients with chorea. The speech of the typhus patient is somewhat similar to that of the paretic: The difference between the two dysarthrias lies in the fact that the typhus patient is able to correct his speech defects almost completely upon strenuous repetition of the test word, whereas the general paretic produces assonant, senseless syllables, upon repetition.

Other authors attribute the responsibility for the speech defect to bulbar lesions. Observations on the writer's patients, and on himself as well, showed that there might be another simple explanation to be taken into consideration. The swollen, dry, fissured, painful tongue rendered the speech, mastication and deglutition difficult and distressing, not merely for days, but sometimes for weeks. Besides, the pathological findings in the cranial nerves lead one to believe also in the possibility of a temporary involvement of the hypoglossal nerve, which might determine peripheral motor speech defect.

Simultaneously with this dysarthria, neuritis of the acoustic nerve is also seen. This could produce exceedingly painful syndromes with varying degrees of deafness. Hypoacusis, or deafness, may last for weeks or months. This acoustic syndrome, occurring during delirium, might be responsible for the acoustic hallucinations and might sometimes cause paranoid delusions.

As another form of reaction of the exogenous psychosis at the height of the disease the so-called amentia may be described. This expression was originally used by the Viennese school of Stransky, is not accepted in the English literature, and has nothing to do with congenital disturbance of intelligence. It is rather a serious syndrome and in rare cases might possibly result in permanent organic impairment. In spite of the fact that the symptoms are of varying degrees, the writer could observe three main clinical forms. All have one common characteristic: incoherence of ideation.

The first form of "amentia" presents the following symptoms: clouding of consciousness with decrease of attention; decrease and complete disorder of the association of ideas; complete disorientation, insufficiency of perception, grasping movements and abulia, which is characterized by indecision, slowness and lack of motor and psychic impulse. The symptoms present themselves slowly; the patient begins to speak incoherently in a monotonous way, re-

peating the same questions over and over. In many patients, there is often a bewildered and perplexed condition. In the beginning, the patient can be recalled from this state of confusion; gradually he gets into an excited, emotionally unstable mental state. Rabiner attributes the grasping movements to a disturbed function of the frontal lobes—which he thinks occurs most of the time—in a borderline state between consciousness and unconsciousness.

The second form of "amentia" exhibits the so-called isolated delirious ideas and "psychosensorial disturbances." The confused patient does not present clear-cut systematized ideas, but his expressions are all extracted from an underlying delusion, primarily of persecution, of grandeur, or of self-blame. Very often this condition may be similar to that of a general paretic or of a senile demented individual. The "psychosensorial disturbances" are characterized mainly by illusions which may involve all the senses. The patient sees, in the shadows of the objects in his surroundings, different figures which may be pleasant or unpleasant to him, according to the underlying personality of the patient. Similarly, he hears, in different sounds in his surroundings, acoustic illusions of enjoyable or frightening character. Illusions of taste or smell are rare.

The most serious degree of confusion is observed in the third clinical picture of the "super-acute form of amentia." The patient is a victim of great excitement, which is also enhanced by unpleasant and often erotically-tinged hallucinations. Besides he presents very serious somatic disturbances: marked congestion of the conjunctiva, dyspneic respiration, profuse sweating, very high temperature and slow arrhythmic pulse. These symptoms lead most of the time to a fatal issue, and they permit one to understand the expressions used by Bonhöffer: "moments of exhaustion" and "vegetative deterioration."

In the third week of the typhus disorder, the delirious picture and the psychic disturbances have a tendency to subside with a decrease of the fever. The patient begins to quiet down. The return of reality, its perception, and the recognition of persons and objects in their surroundings leave a vivid impression. The experiences of the deliria are felt like those of a chaotic dream. For the states of confusion, there is generally amnesia. In a poor physical condition with a vague headache, photophobia, a pares-

thesia and a great weakness in the lower extremities, the author himself lay in an apathetic state, without any particular mental activity—with a fatiguing attempt to perceive the surroundings, with marked distraction, and with impossibility of concentration and logical thinking. It was a condition of drowsiness, with a permanent buzzing in the ears. With the gradual improvement of the general condition, the mental capacities recovered, and the shallow affect was now replaced with emotional instability, with spells of crying and childish behavior. Bonhöffer calls this condition "hyperaesthesic emotional weakness," in which a euphoric state often appears as an expression of the healthy, reactive, convalescent phase.

During this mental syndrome—at times for a period of months—it is possible to notice marked vegetative disturbances, such as loss of hair, increased dermographismus, and a long-lasting thirst which apparently is due to a stimulation of the diencephalic region. Besides this, there are symptoms of a cerebral ataxia, remnants of paralysis of the ocular muscles, and Korsakoff-like syndromes. The latter mostly are observed in elderly persons as a direct passage from the delirious condition.

In very serious cases, the delirium may pass, with a decrease of fever, in a very serious, stuporous apathy, which Jenner has called "*coma vigile*," which is characterized by a deep disorder of motility and of speech. In extremely serious cases, muscular activity may be completely inhibited, giving the impression of a catatonic schizophrenic syndrome. Such patients have the eyes widely and rigidily open, exhibit slight myoclonic contractions around the mouth and the nose, tremor of the hands, frequent muscular contractions of the arms and legs, a very marked dysarthric, unintelligible speech, and an increasing circulatory failure which generally leads to a quick death.

The most interesting observations of the so-called "residual insanity" of convalescence were described in a previously-published paper.

There remain to be described several observations during the later convalescent stage. There were noticed in this period conditions characterized by marked disorders of the affect, which secondarily could lead to abulia and also, perhaps, sexual anesthesia; disturbances of the proprioceptive sensations, especially of the lower extremities, difficult speech and varying degrees of deafness.

Significant changes of affect can be observed immediately after the drop in temperature. They are masked in the beginning by the still-existing clouding of the sensorium, but gradually they appear more and more. The patients are extremely selfish, completely deprived of their higher moral, human tendencies, absolutely disinterested in their surroundings or family members, having in their minds only the satisfaction of their great hunger. This indifference and selfishness can be conscious or unconscious. In the first case, the patient may develop a depression, because of his (varying) degree of helplessness to improve his mental condition. Unconscious indifference makes the patient appear like a schizophrenic.

The symptom of abulia is apparently connected with the foregoing condition. The patients may have marked decrease or weakening of the will power for months, without vital energy and initiative. The symptoms may be so pronounced, that the patients are unable to take care of their most simple physiological needs or bodily hygiene. In many cases, months are required before patients are in condition to accomplish systematic work.

"Sexual anaesthesia," which lasts weeks or months after the recovery from the physical symptoms, means a lack of sexual desire and an absolute indifference toward the opposite sex. Three presumptive explanations for this disorder could be given: first, a schizophrenic-like mental condition; second, possibly reversible pathological impairments of different nervous centers; and, third, possible functional or reversible organic impairment of the endocrine system. Women patients suffer from amenorrhea over periods of many months. This disappears completely after full physical and mental recovery. The proprioceptive disturbances are usually observed in the lower extremities. For weeks, sometimes for months, the legs are as if made of wood. This trouble also causes insecurity of the gait, at times so markedly that the patients are compelled to learn to walk again, like children. The difficulties of speech and the varying degrees of deafness, which are the continuation of troubles originating during the height of the disease, can also last a long time after the disappearance of the fever.

Following these illustrations, the writer wants to give, on the basis of his own material, some statistical data which may be used

as practical indications for prognosis. Serious psychic disturbances at the beginning of the disease occur in approximately 45 per cent of the cases. Among these, "amentia" is the most frequent; only one-fifth of the psychically-affected patients experience the trance-like conditions. The patients with severe psychic disturbances also show serious circulatory impairment, resulting in a mortality rate of as high as 30 per cent.

Slight psychic disturbances, which occur most frequently at the height of the disease, such as the oneiric deliria and hallucinosis, are observed in approximately 35 per cent of the cases, with a relatively favorable prognosis. About 15 per cent exhibit various psychic syndromes of severe and slight nature, which occur mostly in the second week of the disease and which last, in many instances, beyond the convalescent stage.

The psychic syndromes called "residual insanity" are rare. The writer has seen only three such cases.

The psychic disturbances which are noted even many weeks after recovery from the infectious disease occur in approximately 75 per cent of the cases. However, these disturbances did disappear with time.

Neurological syndromes and vegetative disturbances were seen in 5 per cent of the cases observed by the writer. The prognosis in these cases is good as regards life, but poor in regard to neurological involvement, the result being permanent contractures, paresis, athetosis and even paralysis. The majority of children and adolescents up to 18 are able to withstand and overcome the disease, provided the general state of nutrition is not too impaired. These young people are less inclined to psychic disturbances. From 18 to 30, oneiric deliria and hallucinosis are outstanding psychic symptoms. From 30 to 45, the manic and trance-like syndromes are most frequent; from 45 to senility, the "amentia" cases. The foregoing subdivision held for 70 per cent of the cases seen by the writer, whereas the remainder might embrace any type of psychosis regardless of age.

Typhus fever—because of major and severe epidemics during wars, famines and other periods of human misery, is considered one of the most significant of infectious diseases. The writer feels that his description of the psychic disturbances during its course

may, on the one hand, help in understanding prognosis in the clinical picture and, on the other hand, contribute modestly to the problem of the correlation between infectious disease and psychosis.

Summary

This paper deals with the most interesting of the psychic disturbances observed in 430 cases of typhus seen during two great epidemics in eastern Europe in the years 1941 and 1945. These mental disorders accompanied the disease from the prodromal stage through the peak and decrudescence, through convalescence and even later. There were observed, especially at the beginning of the disease as well as at its height, varying degrees of confusion, disturbances of speech, "double image" illusion, different types of delirium (simple and "oneiric"), manic conditions, hallucinosis, different degrees of "amentia," the Korsakoff syndrome and others. The "double image" syndrome and the "oneiric" delirium were experienced by the author himself, while he was ill with the disease. Observations during convalescence included: abulia, so-called "sexual anesthesia," proprioceptive disturbances, speech disorders and hypoacusis. Three cases of "residual insanity" have been described in another published paper. In 25 cases, clinical syndromes were observed which were probably due to conditions of acute hypoglycemia or adrenal insufficiency.

A statistical survey is presented in which an attempt is made to correlate prognosis with mental symptoms.

Binghamton State Hospital
Binghamton, N. Y.

BIBLIOGRAPHY

Blumberg, N.; Doane, J. C.; and Weiss, L. B.: Brill's disease. N. E. J. Med., 241: 479, 1949.

Binford, C. H., and Ecker, H. D.: Endemic (murine) typhus; report of autopsy findings in three cases. Am. J. Clin. Path., 17:797, 1947.

Bonhöffer, K.: Die exogenen Reaktionstypen. Arch. f. Psychiat. u. Nervenkr., 58, 1917.

Guttmann, O.: Akuter Infekt und Residualwahn. Wien. med. Wchnschr., 97:411, 1947.

Kehrer, F., and Kretschmer, E.: Die Veranlagung zu seelischen Störungen. Julius Springer. Berlin. 1924.

Kleist, K.: Episodische Dämmerzustände. Thieme. Leipzig. 1926.

Martin, J. P.: Consciousness and its disturbances. Lancet, 1:1, 1949.

Muncie, W.: Psychobiology and Psychiatry. Second edition. Mosby. St. Louis. 1948.

Peterson, J. C.; Overall, J. C.; and Shapiro, J. L.: Rickettsial diseases of childhood. J. Pediat., 30:495, 1947.

Sadler, W. S.: Modern Psychiatry. Mosby. St. Louis. 1945.

Snyder, J. C.: The typhus fevers. In: Viral and Rickettsial Infections of Man. T. M. Rivers, editor. Lippincott. Philadelphia. 1948.

von Stockert, F. G.: Die psychischen Störungen bei Fleckfieber. Deutsche med. Wchnschr. 69:506, 1943.

Stuart, B. M., and Pullen, R. L.: Endemic (murine) typhus fever; clinical observations of 180 cases. Ann. Int. Med., 23:520, 1945.

Wolff, H. G., and Curren, D.: Nature of delirium and allied states; dysergastic reaction. Arch. Neurol. and Psychiat., 33:1175, 1935.

PREFRONTAL LEUKOTOMY: A CLINICAL SURVEY OF 100 CASES GIVEN AN ACTIVE RETRAINING PROGRAM IN A MENTAL HOSPITAL---ADDENDUM

BY MAURICE KLOTZ, M. D., WALLACE P. RITCHIE, M. D., AND BURTRUM B. SCHIELE, M. D.

In the paper of this title by the writers, appearing in the January 1952 issue of THE PSYCHIATRIC QUARTERLY, the authors' calculations for Tables 4, 5 and 6 (results of leukotomy in relation to age, duration of illness and duration of hospitalization) were presented in place of the tables themselves. These calculations, headed Tables 4, 5 and 6, appeared on pages 61, 62 and 63 of the original article. Discussion of the figures in the text on those same pages refers, not to the tables shown, but to those which did not appear.

The tables which should have appeared in the January 1952 paper, and which should now be read in relation to it, follow:

Table 4. Results in Relation to Age at Time of Leukotomy

	Out of hospital		In hospital								
Class	0	1	2a	2b	2c		3	4	5		
Age	Excellent	Good	Good	Moderate	Fair	Total Improved	Same	Worse	Died	Total unimproved	Total in age groups
20-25	0	3	1	2	3	9	1	0	0	1	10
26-30	4	6	2	5	6	23	2	0	2	4	27
31-35	0	5	3	2	1	11	3	1	0	4	15
36-40	0	2	0	5	2	9	1	0	0	1	10
41-45	3	0	3	1	3	10	0	0	0	0	10
46-50	0	0	2	0	2	4	1	0	0	1	5
51-55	0	0	1	4	2	7	2	2	1	5	12
56-60	0	0	2	3	2	7	2	0	0	2	9
61-65	0	1	0	0	0	1	0	0	1	1	2
Totals by class.....	7	17	14	22	21	81	12	3	4	19	100

Table 5. Results in Relation to Duration of Illness Before Leukotomy

	Out of hospital		In hospital								
Class	0	1	2a	2b	2c		3	4	5		
Years	Excellent	Good	Good	Moderate	Fair	Total improved	Same	Worse	Died	Total unimproved	Number in each group
2-3	1	8	0	1	2	12	2	0	0	2	14
4-5	3	4	4	9	6	26	4	1	0	5	31
6-7	2	3	2	5	2	14	1	0	1	2	16
8-10	1	1	1	0	2	5	0	0	0	0	5
11-15	0	0	4	1	4	9	0	0	3	3	12
15 plus	0	1	3	7	4	15	5	2	0	7	22
Totals by class	7	17	14	23	20	81	12	3	4	19	100

Table 6. Results in Relation to Years in Hospitals Before Leukotomy

	Out of hospital		In hospital								
Class	0	1	2a	2b	2c		3	4	5		
Years	Excellent	Good	Good	Moderate	Fair	Total improved	Same	Worse	Died	Total unimproved	Number in each group
1-3	5	10	4	9	3	31	5	0	0	5	36
4-6	1	5	2	4	8	20	2	1	1	4	24
7-9	1	1	2	1	4	9	0	0	1	1	10
10-12	0	0	1	1	3	5	0	0	2	2	7
13-15	0	0	2	1	2	5	3	1	0	4	9
16-18	0	1	1	3	0	5	1	0	0	1	6
19-21	0	0	0	0	0	0	0	0	0	0	0
22-24	0	0	2	0	0	2	1	1	0	2	4
25-27	0	0	0	1	1	2	0	0	0	0	2
28-30	0	0	0	2	0	2	0	0	0	0	2
Totals by class	7	17	14	22	21	81	12	3	4	19	100

Veterans Administration Hospital
St. Cloud, Minn.
and
University of Minnesota Hospitals
Minneapolis 14, Minn.

EDITORIAL COMMENT

LO, ALL OUR POMP OF YESTERDAY . . .

We can only express awe at the audacity and immensity of a proposal to enlist the most eminent authorities of today for collaboration on an unbiased and definitive history of mankind. To be supported by the United Nations Educational, Scientific and Cultural Organization and private funds, to cost $600,000 or upwards, to involve the co-operation for five years of 1,000 leading scholars of both Occident and Orient, this is an effort which one must believe surpasses in aim and scope any other single endeavor made in the social sciences in the long story of the human race.

As we understand it, the purpose of this colossal undertaking is to present in six basic volumes and suitable abridgements, for teaching and general reading, a view comprehending all the world's people in a record of humanity since our species first saw the light of the sun. History in every land has been presented from biased viewpoints. With a common language and fairly accessible bodies of facts, the tale of the American Civil War is reported differently in north and south, and that of the American Revolution differently in the United States and Great Britain. French and German histories of identical events differ still more; and we reach the fantastic in considering history as written in the rest of the world and that behind the Iron Curtain. If we could, for once, determine the facts of human events and teach them objectively, we should accomplish more than can easily be imagined toward ridding ourselves of one of the great pestilences which scourge mankind, paranoid hatred and distrust of peoples who are strangers.

What we should thus rid ourselves of is at least part of the accumulation in human consciousness of untruth, half-truth and fanatic distortion that has clouded the thinking of man-at-arms since flint knives were first used for throat-slitting. We should not be rid of it all, of course; and we should not be rid of any of the vaster and blacker prejudices of the unconscious, which are a greater danger than all the false histories ever recited or written since Cain lied to the Lord about Abel. But a reasonably objective presentation of the past of man on the intellectual level is certainly a first step toward emotional understanding of the truths of

the essential unity of humanity and the essentially common interests of the race. And it would be a long first step toward human progress and world peace. We would not be far wrong, we believe, if we conceived some such thing as this as a major aim of the distinguished group which is collaborating on UNESCO's history.

No scientist concerned with the facts or the interpretation of human behavior could be indifferent to such a project or do other than wish wholeheartedly for its successful accomplishment. But no psychiatrist can do other than see how large loom the obstacles to be cleared from the road of objectivity. Perhaps one could illustrate best by a few examples—imagined or real—of the problems which will have to be solved by the scholars.

History, in its broad sense, of course includes what we commonly call prehistory. Of the six great volumes into which the collaborators will attempt to condense the history of the world, the first will be divided into two sections, the first devoted to prehistoric times and the second to the "rise of the first urban cultures in the Ancient East." (The quotation is from the statement of scope and contents made public when the announcement of personnel and plan was made last December.) Among the specific topics to be covered are "the differentiation of the human type, the origin of the existing species of man and its spread over the earth, and the achievements of paleolithic and neolithic peoples." And to proceed, there are the problems of the creation of symbolical systems, art and ritual, magic and myth, spoken and written language. There are problems of the development of law and other means of social control, and the considerable problem of the development of abstract thinking.

But what are the ascertainable facts in all these—and many other—instances? The beginnings of humanity are of considerable interest to psychiatry because of the biological, which is to say medical, problems involved; and because at least two psychiatric schools, those of Freud and Jung, have developed important theories of the psycho-biological origins of human culture.

If there is anything like general agreement on the human family tree, we interested onlookers at anthropology are not well-informed about it. The relationship of the human branches to the primate trunk may be a little clearer than it was a generation ago, but it is by no means known definitively. Whether this or that "extinct" variety of fossil man was a direct or collateral ancestor of

modern man can still be debated. Has brutish Neanderthal man really become extinct, as once supposed, or did he develop into "progressive" and "conservative" varieties, with the former ancestral to ourselves, perhaps through mutation? And what connections have today's Negroid, Mongoloid and white varieties with various "ancestral" types, and among themselves? We know the links of our own type to other peoples are closer than once supposed; but the sum of our present information is not extensive.

When one leaves physical for cultural anthropology, there is controversial material which—to the onlooker—would seem sufficient to fill at least 600 volumes, instead of the part of one volume projected for this subject. Suppositions of the origins of culture have advanced from the naïve to the confused. One doubts if any anthropologist today visualizes early man as living in unorganized, primeval groups in a state of complete promiscuity. But there are still upholders of Westermarck's contrary theory that early man was monogamous and that divergent familial organizations are phenomena of social degeneration. The earliest theories of the matriarchate have been substantially modified or abandoned; but there is still room for endless controversy over the position and significance in human development of the matriarchal systems which plainly preceded many patriarchal societies of historic times, or for dispute over the traces of matriarchal institutions which are evident in some of the societies of our own times.

Probably few anthropologists today would consider Freud's unmodified primal horde theory to be sufficient explanation for the development of human social organization; but its possible role in the development of patriarchal institutions is difficult to disregard; and the wider concept of the Oedipus complex must at least be considered, whatever the social framework. Even more broadly, a report on early human development must take account of the psychological basis on which all our institutions have been erected. Since we believe that there is no general agreement on this psychological basis, we may be tempted to express selfish relief that it will be the task of the historians, not of the psychiatrists or psychologists, to try to summarize human knowledge on this subject.

One may think of this as one example from possible thousands which must be met at the very outset of the historians' project. It may be suspected that they will multiply as the workers endeavor to trace the tale of mankind through years, centuries and

millennia. Before the end of Volume I, the historians will have to find fitting place for the Elamite, Sumerian, Egyptian, Hittite and Minoan peoples. Here will have to be evaluation from records which we know are incomplete, from hostile records—and from architectural remains and fragments of stone, pottery and metal work where records cannot be read or do not exist at all. With thousands of generations of human life and human achievement already in the past, the keeping of records which men's descendents could read had barely begun.

One cannot write history, of course, without coming to conclusions. To simplify, one writes such things as: "The battle of the Boyne [or Agincourt, or Saratoga, or Salamis, or Midway] resulted in . . ." In Volume II of their world history, the writers will, of necessity, have to explain what the battle of Salamis, and many other encounters, some of which may not even be described or mentioned, did "result in." Most of us with vague recollections of high school or college history have some idea of the results of Salamis; that is, we think of it as the turning point in the struggle which determined that Greek culture, not Persian, would dominate the eastern Mediterranean. With the European tradition and point of view, which the peoples of the Western Hemisphere share, this triumph of the Greek has generally been considered an unmixed blessing for progress and humanity generally. One may wonder whether, from the world point of view, which the historians will seek to attain, the verdict should not be modified. Certainly the Persians, whose empire fell before the Greeks a century and a half later, did not share the traditional opinion.

One could raise on nearly every page of history what Franklin D. Roosevelt used to call "ify" questions. "If Carthage had given unstinted support to Hannibal after Cannae . . ." "If George III and William Pitt, the elder, had not been psychotic at the wrong times . . ." And in our day, the "ify" question of the historical position of Roosevelt himself.

There is a London fog of such problems. Man, of course, has not always gone onward and upward. He has regressed, as well as progressed. But he has been loath to admit it in his histories. One conspicuous exception has been the fall of Rome. How Europeans (and North and South Americans) have felt about the fall of Rome may be judged from one term for the immediately succeeding centuries, "the dark ages." But from the long-range point

of view of the world as a whole, was the fall of Rome as great a disaster as we have generally conceived it? Were the rise of the power of Rome and the creation of the empire as great benefits?

It has been observed since long before Carlyle that traditional historical teachings, coupled with the cult of the great man, can lead to extraordinary distortions. To cite random examples, we once knew a Latin teacher who—while maintaining firmly that Jesus was the greatest figure in the annals of this earth—believed that Julius Caesar was unquestionably the second. And to the contrary, one could cite an Anglo-American novelist of a quarter-century ago whose books carried on a personal war of almost paranoid intensity against long-dead Caesar. We know, or think we know, that Caesar extended the rule of law and order and established a pattern which led to progress over wide areas of northern and western Europe. But we also know that Caesar was tyrannous and treacherous and that he had a heavy hand in war. And most of what little we know of the Helvetians, the Gauls, the Germans and the Belgians are from the reports of this implacable enemy.

Hitler was not the inventor—as he was not the latest user—of the "Big, Big Lie." The invention of writing was of inestimable benefit to the liar. He scratched his lies in clay; he painted them on plaster, penned them on papyrus. Rameses II engraved a collection on the walls of Karnak which would have astounded Ananias. Fortunately the liar often over-reached himself; fortunately, too, one can sometimes ascertain the truth by studying the records left by competing liars; and, fortunately, too, erasures leave traces, as witness the attempts of Thutmosis III and successors to wipe out the memory of the great Queen Hatshepset.

All this is elementary, and quite likely very bad, commentary on the general business of writing history. It is an amateur excursion to the historical kindergarten, undertaken not for the benefit of historians, but for those of us who too often fail to appreciate the materials and the difficulties of their work. In UNESCO's world history endeavor, it seems to have been abundantly recognized. An American heads the editorial group; the writers of the volume on prehistoric and ancient times will be British, as will the writer of the history of the ancient classical period. With the fall of Rome, comes a new point of view. What we have thought of as the "dark ages," the middle ages, or medieval times, will be treated

by the historians as "the Asian Age," its accomplishments recorded from the viewpoint of culture creativeness in China, India and Southwestern Asia. A Frenchman will write this volume. An American will write of the "European Age," from A. D. 1300 to the opening of the nineteenth century; and a Peruvian will write of that century. The director of the historical division of the Ministry of External Affairs of the Republic of India with write Volume VI, covering the first half of the twentieth century. Here is an extraordinary effort, by choice of personnel, to obtain a world viewpoint and to divorce history from nationalistic pride and nationalistic prejudices. And if scholars from the countries behind the Iron Curtain are not represented, we are assured that efforts will be made to treat their histories respectfully and impartially in their absence—and, besides, the Soviet view of the past is only an exaggeration of the sort of history we are trying to get rid of.

It will be difficult, one may think, to write history free of all the distortions satirized in Orwell's "1984." But with the intent announced and the collaboration in prospect for this UNESCO effort, we think a reasonable facsimile of a consciously unbiased world history may be accomplished. What is closer to our own specialty and to our own interest in the project is the question of unconscious bias. We, and our carefully selected UNESCO historians, cannot escape altogether from our culturally-determined and psychologically-determined frames of reference. Our history writers, and most of their collaborators, will come, for example, from generally patriachal, from chiefly monotheistic, and, for the most part, from at least theoretically monogamous societies. All these factors produce definite unconscious mental patterns. How will the unconscious pattern of the historian from a monogamous society react to a polyandrous culture? How, in spite of long cultural acquaintance with Egyptian, Greek, Roman and Norse gods, will the modern monotheist react to modern polytheistic societies? How will the person from the fully-developed patriarchal society (and the societies of all the writers noted are such patriarchal groups) make impartial appraisal of matriarchal society? Can such subconscious or unconscious attitudes be compensated for in compiling impartial records of history?

It is not so long since our culture was afflicted with what was called the economic interpretation of history. It was a fairly rea-

sonable interpretation, as far as it went. But as far as it went was the assumption that man was a purely economic creature. And we have seen too many human developments in recent years, in which the motivations were plainly other than economic, to have much patience with further economic interpretations.

Similarly, there was once a "great man" school of history, which was plainly a reaction to personal or cultural Oedipal problems. And the cultural school which denied the existence of great men was a similar reaction. Finally, the subjects to be included in a history, the position of technical and cultural achievement, the relative importance of the fine arts and of man's efforts to dominate his fellowmen, these and infinitely more questions will be subject to unconscious influence. How our UNESCO historians cope with these things will be of as great interest and significance as their final product of a world history.

BOOK REVIEWS

A Handbook of Psychosomatic Medicine. By ALFRED J. CANTOR, M. D. 295 pages. Cloth. Julian Press. New York. 1951. Price $5.00.

In this book the author presents his theories and methods of psychotherapy in the treatment of psychosomatic problems, chiefly, gastro-intestinal disorders. The trained psychiatrist will question whether Dr. Cantor has presented any new ideas. On the other hand, many physicians may understand the terminology and methods which the author uses better than those used by the psychiatric specialist.

In his preface, the author states, "Guided association analysis (silent level therapy) is an endeavor to synthesize a great many useful methods already well known in the field of psychotherapy." He believes that psychoanalysis, psychotherapy and counseling have failed many times because, "Both the patient and the physician are in the main merely manipulating symbols—words, words, words—*only words!*" He feels that only "occasionally during conventional analyses the patient will *relive* a situation of emotional conflict and will burst into tears. There may be rage or other affect. At these points the patient has touched the silent level. In such a case therapy will be more effective. . . ." This is what the author refers to as "silent level therapy."

In other terms, emotions must be closely connected to words and to action ("reliving") if good results are to be expected, "Words are not the things they represent. . . . The word chair is not actually a piece of furniture. You cannot sit on the word. . . . Now let us consider the same patient in guided association therapy. The death situation is relived with full affect. The patient 'is' six years old and is crying bitterly in grief and terror, pretty much as he did at the time of the initial episode. The tears, sobs, the *feeling* of grief and terror, are on a silent level. . . . Although the patient will be talking during this reliving experience, the therapy will result from silent level expressions (tears, etc.). . . . Thus, repeated reliving of the emotional distress is essential. Guided association therapy insists upon such reliving until more complete emotional discharge is achieved. . . ."

Dr. Cantor calls attention to the importance of semantics. He suggests that the therapist often forgets to follow up the emotional interpretation of words: i. e., What does the word "tumor" or "colitis" or "fire" mean emotionally?

The last two-thirds of the book is a compendium of gastro-intestinal disorders.

Dynamic Psychiatry. Franz Alexander and Helen Ross, editors. 578 pages. Cloth. University of Chicago Press. Chicago. 1952. Price $10.00.

This book attempts to present to the various related professions and to students of psychiatry, a comprehensive view of a new approach. Fifteen eminent specialists in medicine and related disciplines have made contributions to a dynamic psychiatry which recognizes the mutual interrelation of the fields of psychoanalysis, general psychiatry, psychology, social anthropology and general medicine.

Sixteen chapters, each written by an authority on the specific topic, are divided into three sections. The first presents the theoretical formulations underlying a dynamic psychiatry; the second shows the clinical application of such an approach; the last demonstrates the influence of dynamic psychiatry on such fields as medicine, social anthropology, and clinical and animal psychology. Perhaps one of the more important chapters is that dealing with current thought, since it is here that the far-reaching impact of psychoanalysis is made evident. Such diversified fields as religion and economics are considered, and one wonders at the sorrowful omission of a section on international relations. Of particular value are the extensive bibliographies which are compiled at the end of each chapter.

Dynamic Psychiatry notes that psychoanalysis is not an isolated phenomenon but rather part of a whole, whose sum becomes greater because of it.

Progress in Neurology and Psychiatry. An Annual Review, Volume VI. E. A. Spiegel, M. D., editor. 549 pages. Cloth. Grune & Stratton. New York. 1951. Price $10.00.

As in previous volumes of this series, Volume VI contains a tremendous quantity of abbreviated information. Because of this, it is not possible to review it adequately. One can best say that it is an up-to-date encyclopedia of information on neurology and psychiatry during the year 1950.

It is divided into four parts: the basic sciences which cover the anatomy, physiology, pathology and pharmacology of the nervous system, clinical neurology, neurosurgery and psychiatry. Furthermore, one can also roughly divide the book into two parts: 350 pages of neurology and 200 pages of psychiatry.

One recognizes that *Progress in Neurology and Psychiatry* is addressed primarily to the specialist, but the material is well organized and each chapter is followed by numerous references. For these reasons, the volume will be of great help to any physician who needs to do investigative studies of neurological or psychiatric subjects. Therefore, every medical library should contain these annual reviews.

Handwriting—A Key to Personality. By KLARA G. ROMAN. 382 pages with over 400 handwriting samples. Cloth. Pantheon. New York. 1952. Price $6.50.

Graphology is as old as the awareness of the manifold personal differences in handwriting. Only within the last hundred years, however, has graphology undertaken to become a science by trying to verify and classify its findings systematically. There were many difficulties in the approach to such a systematic research. The psychology of personality and characterology, on which graphology has to be based, is still in its early development, and the same is true for the systematic study of human expression, motoric expression and the knowledge of gestural communication. Nevertheless, many an intuitive graphologist has been able to give a good character diagnosis after careful study of someone's handwriting.

That the present reviewer asks the psychiatrist's attention for this new book on handwriting has its basis in modern psychological developments. Thanks to the use of projective techniques in psychodiagnostics, psychiatry's attention to the direct creative expression of patients is growing. We analyze these expressions as we analyze other communications. The study of graphology helps in the scientific analyis of these motoric communications.

Klara Roman (who came to this country after she had already made her name as a Hungarian graphologist) is an excellent guide. Her work, as shown in her book, has reached a high scientific level. After an investigation of playful scribbling, doodling and casual drawing, she leads the reader gradually into an awareness of how conflicts are reflected in our graphic attempts. Her following chapter describes the more thorough analysis of writing pressure and gesture. Physiological and statistical study of graphic indices is possible.

In much of her objective research, the author has been a pioneer, especially in her work on writing pressure. Only after thorough physiological analysis, are readers allowed to give more attention to the symbolism of the writing space, and to the manifold ways in which people hide and express themselves in the partly conscious, partly unconscious, act of handwriting.

One finds in this book many different illustrations of the various human expressions in handwriting, and the book closes with sample analyses of five cases.

This reviewer is sure that the graphologist will become an integral member of the diagnostic team for both organic and psychological diagnosis. This book will be a helpful guide for all those who want to expand their diagnostic techniques.

A Manual for Psychiatric Case Study. By KARL A. MENNINGER, M. D. 341 pages. Cloth. Grune & Stratton. New York. 1952. Price $6.75.

Dr. Menninger is correct when he states, in his preface, that a book systematically describing the proper procedure in psychiatric case study is badly needed for the training of students and young doctors who are studying psychiatry. He calls his book a manual. It is more than this. It is a book in which Dr. Menninger not only gives an outline of procedure but is one in which the reader can almost imagine the immediate presence of a person who is dispensing friendly advice.

This book covers every aspect of psychiatric case study. In Part I, the author tells the reader how to approach the patient, how to question him, and describes various reactions which the patient may have toward the examiner. Dr. Menninger describes the proper methods of collecting historical data; the meaning and importance of items of historical data; the proper approach to physical and psychological examinations and how to evaluate or analyze the data collected.

Part II deals with a therapeutic program, the importance and methods of keeping proper records and of making case summaries. The author includes in this section a chapter on medical ethics and referral of patients as well as several examples of letters which can be written to the referring physician.

Part III records several complete case records which follow the recommended form and which can be used for reference.

The appendix contains the new American Psychiatric Association Nomenclature, the Standard Veterans Administration Nomenclature, a list of personality types, a tabulation of adjunctive therapy modalities, references to a model commitment law and a list of references or recommended reading for the student.

The Case Against Psychoanalysis. By ANDREW SALTER. 179 pages. Cloth. Holt. New York. 1952. Price $2.50.

"Modern psychology has shown Freud's map of the mind to be as inaccurate and wildly fanciful," says Andrew Salter, "as the pre-Columbus map of the New World, and practical experience has shown psychoanalytic therapy to be insipid and unimpressive in its results. Consequently, even those who are still practising its methods have become filled with doubts. . . ." This reviewer wonders where Salter has been. Salter misunderstands and misinterprets. One could cite his discussion of free association as a masterpiece of misunderstanding.

This book is to be recommended to the informed as a clearly-written exposition of the views of some of the more fanatical anti-Freudians. It is not a work, however, which one would recommend unhesitatingly to the novice in search of unprejudiced information.

Modern Psychiatric Shock Therapy. (*Die Moderne psychiatrische Schocktherapie.*) By Prof. Dr. med. WALTER RITTER VON BAEYER, director of the psychiatric and neurologic department of the General Municipality Hospital of Nürnberg. 160 pages, including preface, bibliography and index. Paper. George Thieme-Verlag. Stuttgart. 1951. Price: DM 14.40.

This monograph on "modern treatment of the psychoses by shock methods" is rather unusual in the German psychiatric literature, especially as it also utilizes the international literature to advantage, in a critical selectivity. The well-known author reviews not only the history and the fundamentals, and describes the methods of the different types of shock treatment in a very clear and comprehensive manner, but he gives valuable material on the clinical effects of the treatment in the different phases of all types of mental disorders. Clinical records from his own experience are well presented.

The bibliography and index are highly satisfactory. The critical attitude, the clear style, and the wide experience of the author make this compendium both a good introduction and valuable handbook for the practice of psychiatric shock therapy.

Die Grenzen Der Psychotherapie. By G. EWALD. 35 pages. Cloth. Georg Thieme Verlag. Stuttgart. Price DM 3, 30.

The author, professor of psychiatry at Göttingen, reviews the "limits of psychotherapy," arriving at ambiguous results. He is—though full of ambivalence even in his rejection—opposed to Freud, criticizes Adler, and is rather friendly toward Jung. Regretfully one notices that Ewald misunderstands in many points what psychoanalysis stands for; many of his objections are based on specific misunderstandings. Newer findings are no less misunderstood, or are not even mentioned. Amusingly enough, Ewald is even opposed to didactic analysis; according to the author, it creates only a sect, *which he compares to the Ku-Klux-Klan.*

Case Histories in Psychosomatic Medicine. By the Staff of the Psychiatric Service, Massachusetts General Hospital, Boston. Edited by Miles, Cobb, Shands. 301 pages. Cloth. Norton. New York. 1952. Price $4.50.

Twenty-one cases of clinical presentations with discussions are adduced; the underlying principles are: "Our case histories are psychoanalytically oriented, but do not involve intensive efforts to reconstruct and interpret unconscious material [Foreword, X]." By limiting the scope of investigation, the authors deprive themselves of many advantages, though they achieve an over-all picture, details of which are open to discussion.

Current Therapy, 1952. Latest Approved Methods of Treatment for the Practicing Physician. Howard F. Conn, M. D., editor. 849 pages. Cloth. Saunders. Philadelphia. 1952. Price $11.00.

This is a big book, containing a tremendous lot of information about the treatment of almost every important disease. If a doctor has the book close by, and if he has made the diagnosis, he can get advice as to treatment in "one, two, three" order.

Current Therapy, 1952, is similar to the volumes of 1949, 1950, and 1951, but it is a larger book and contains more information. The contributors have been carefully selected, so that the methods are set down briefly, to-the-point, and in the exact detail necessary, by a doctor who is a recognized authority in the treatment of the disease concerned. In some cases, two or more methods of treatment of disease are given, each by a different authority. The editor advises that: "The articles are original and have been written expressly for this volume. All the material has been reviewed by the authors just before publication to assure the inclusion of the latest standard therapy."

The last section of the book contains: "A Roster of Drugs" which lists name, manufacturers, etc., of each drug recommended in the book; a "Table of Metric and Apothecaries' System"; and "Tables for Making Percentage Solutions." There is a huge index.

Psychoanalytic Explorations in Art. By Ernest Kris. 318 pages. Cloth. International Universities Press. New York. 1952. Price $7.50.

This is a collection of 14 previously published papers (1933-49), superficially brought up-to-date by numerous footnotes. Even overlooking this technique of "writing" a book (which therefore lacks continuity), more serious objections remain directed against the sterility of the negativistic approach:

"And yet it is significant that we have remained incapable of penetrating to the central problem which evaded Freud's ingenuity. . . . We have no answer to the question why an individual with the infantile experience and the particular pattern of defenses Freud was able to reconstruct in Leonardo's life history was fated to become the great creator. . . . Even when we are in a position to rely on the innumerable and detailed observations which clinical study of creative individuals in psychoanalytic observation and therapy brings to the fore, this question remains unanswered [p. 19]."

Other analysts, e. g., Bergler (*The Writer and Psychoanalysis*), have been refuting this pessimistic *a priori* deduction, and have pointed to clinical material which Kris does not provide. He prefers to theorize and philosophize. The result is disappointing and unsatisfactory, especially since he takes refuge behind stilted-pompous language.

Any Wife and Any Husband. By JOAN MALLESON. 232 pages. Cloth. Random House. New York. 1952. Price $2.75.

A British female gynecologist provides ABC information for the layman on common sexual disorders. The author's attitude is sympathetic; she even accepts some psychiatric-psychoanalytic principles. By oversimplification, overpopularization, and repeating some outworn medical misunderstandings (the chapter on the genesis of homosexuality is the poorest), the author counters her own aims. Strangely enough, she is modern enough to accept the differentiation between clitoric and vaginal orgasm. On the other hand, she speaks of "a new fallacy, the necessity of orgasm [p. 132]," and comes up with a statement like this: "A common and fortunate adaptation is where a woman with vaginal anaesthesia marries a husband with precipitancy [ejaculatio præcox]: then both may be spared making efforts which could end only in frustration [p. 112]." It is amusing that an American publisher seeks his material on sex in England, where Victorian stuffiness is still more prevalent that here, so much so that the author finds it necessary, in enumerating her qualifications to speak about sex, to mention in the preface that she is—a grandmother.

Gesetze und Sinn Des Traeumens. By K. LEONHARD. 146 pages. Georg Thieme Verlag. Stuttgart. Price DM 11, 70.

It is regrettable and rather pitiful that this book on dreams, written by a psychiatrist in Frankfurt, is on the level of 1900. With the exception of the term, the unconscious, everything which dynamic psychiatry accepts as commonplace, is negated by the author. The list of his misunderstandings is quite extensive: He misconstrues the meaning of the "day's residue," neglects symbolism, denies even the "dream censor," the precursor of the later-discovered super-ego. The author is simply not oriented about the last decades of psychiatric-psychoanalytic research—outside Germany. The rather fantastic proposition that the purpose of the dream is to be the bearer and perpetuator of human recollections, can hardly be seriously discussed.

The Single Woman of Today. By M. B. SMITH. 127 pages. Cloth. Philosophical Library. New York. 1952. Price $2.75.

This is a friendly, rather superficial attempt at understanding the plight of single women in England. Although scattered psychiatric material is adduced, the author resorts to angry accusations: "We find that, owing to the long neglect of a sound biological attitude towards mating and owing to bad taste and ignorance, a total lack of informed criteria is so widespread that hundreds and thousands of girls get chosen who should be drastically rejected. . . [p. 20]."

Look Down in Mercy. By WALTER BAXTER. 308 pages. Cloth. Putnam. New York. 1952. Price $3.50.

This novel describes, with peculiar detachment, mingled with sympathy, the plight of a bisexual British captain during the early stages of the retreat in Burma in 1942. The transition from spurious heterosexuality to homosexuality is well depicted—phenomenologically. Growing lack of interest in his wife in England is followed by a casual affair with a nurse; and, finally, consciousness of homosexual attraction to his batman, Anson. Then, once more, the nurse, Helen, is called upon, this time as defense against frightening, consciously perceived homosexuality. Besides his two plagues, Anson and Helen, the captain is obsessed by a third enemy—his "cowardice." But the author shows no understanding of what really motivates his hero—his truly overdimensional psychic masochism. Not the slightest hint is given as to the inner reasons for the captain's triad of troubles. The author is content to evoke pity for the blows which fall on the "innocent" victim.

The whole book is *post-Victorian*: The "post-Victorian" moderns talk about sex in all variations, are even proud of it, and are at the same time victims of good old Victorian scruples. Scruples and remorse are so predominant that *inner motivations are lost*. Post-Victorians as psychological authors are dilettantes; the best they can do is to invoke God's mercy for man's "evil"; despite this invocation, Baxter's marionette takes the external law in his own hands: The captain kills Anson's friend who tries to extort a transfer to the hospital by his knowledge of the homosexual relation to Anson.

Based on external instead of internal guilt, some kind of barter system is instituted; the otherwise—descriptively—well-written book ends up optimistically. Having suffered and vomited (literally) his guilt via overdrinking, the captain is exonerated by himself; the book hints at a happy ending. All in all: Pity and the private mathematics of external guilt cannot substitute for lack of psychological insight.

Dead as a Dinosaur. By FRANCES and RICHARD LOCKRIDGE. 185 pages. Cloth. Lippincott. Philadelphia. 1952. Price $2.50.

The Lockridges here serve up a tasty mixture of psychiatry, paleontology and murder. A question quite as interesting to the reader as the conventional one of "whodunit" is that of whether something new has or has not been devised in the way of a Ganser syndrome. Pam North's well-known intuitions are of import here.

This is not the best mystery which has ever been written, or even the best that the Lockridges have written, but it is first-class North—which should be recommendation enough to any mystery fan, aside from the fascinating question of the psychopathology involved.

The Collected Papers of Adolf Meyer. Volume IV, Mental Hygiene. Eunice E. Winters, editor. 522 pages. Cloth. The Johns Hopkins Press. Baltimore. 1952. Price $30.00 for the four-volume set.

This is the fourth and final volume of a set of books recording the writings of Dr. Meyer. It records his ideas relative to mental hospital care, legal psychiatry, social work, mental hygiene movements, birth control and psychiatric problems related to the child, to the adult and to the community.

Dr. Alexander H. Leighton, who wrote the introduction, briefly reviews the important ideas and ideals which Dr. Meyer expressed in his writings and which are included in this volume. Also, since he was a student of Dr. Meyer, Dr. Leighton gives the reader a clear and intimate picture of Dr. Meyer as a person, as a teacher and as a humanitarian.

One often hears that the ideas in books are old immediately after they are printed. This is not true of the ideas and ideals expressed by Dr. Meyer. As one reads many of his articles, which were written many years ago, one realizes the tremendous influence which his psychiatric philosophy has had in the molding of present psychiatry and psychotherapy.

This final volume contains a bibliography of all of Dr. Meyer's writings, and lists them according to the years in which they were written or published. It also indicates which articles are included in the set, and notes in which volume and on what page these can be found.

Children Who Hate. By Fritz Redl and David Wineman. 253 pages including index. Cloth. The Free Press. Glencoe, Ill. 1951. Price $3.50.

The problem of hate and aggression in children is considered here, not only with the aim of assisting those children who are pathologically afflicted, but also with that of ascertaining the problems of behavior control which confront normal children.

In effect, this is a study of children in whom acute aggression has disrupted normal ego and super-ego functions. Since the extreme nature of their disturbances prevents application of the more common types of individual or group therapy, these children were treated in a specially-controlled environment, Pioneer House, which is a residential group therapy home. There, the goal sought was "not to just see what makes them tick, but to study the disturbances of their behavioral control functions," and the results.

Discussed, are the breakdowns in control, the abnormal defenses utilized, with the emphasis upon what happens to the ego and super-ego functions. The use of actual case material clarifies with realism many of the points made. It is the authors' belief that behind the problems and treatment of "children who hate" lie many of the answers to "the specific functions of the normal ego," knowledge of which is important for the educational handling of normal child behavior in daily life.

The Exploration of the Inner World. A Study of Mental Disorder and Religious Experience. By ANTON T. BOISEN. 300 pages. Cloth. Harper. New York. 1936. Price $4.00.

This book was first published in 1936. The publishers are now reprinting and reissuing it, stating that it originally failed to receive the recognition it deserved. In many respects they are correct, because the book presents the views of a learned man who, on more than one occasion, suffered from acute schizophrenic reactions and who is now able to tell his experiences during and since those episodes. It is important, too, because very few schizophrenics are willing and able to publicize their emotional experiences.

The author, now a minister, has not only been a mental patient but also has been a chaplain in two large mental hospitals, and a research associate at the Chicago Theological Seminary. Thus, he has been able to discuss his ideas, not only in the realms of psychology, sociology and religion, but also in psychopathology. He interviewed many patients suffering from mental disease and has been able to associate the thinking and the problems of these unfortunates with his own experiences. His analyses, therefore, are worth considering by all psychiatrists. His greatest critics may be those persons in his own profession who will probably object to his comparing his own experiences with those of prominent Biblical figures and with other modern disciples. But, the author goes on to show that these important personages profited greatly from their unusual mental experiences. He emphasizes the importance of religion in one's emotional life and the importance of religion as a psychotherapeutic agent. He emphasizes the need for a closer association between minister and psychiatrist.

To help the reader, the author has an appendix to his book. This contains definitions of general, theological and psychiatric terms, as well as brief descriptions of various psychoses.

The Marquis and the Chevalier. Being a study in the psychology of sex as illustrated by the lives of the Marquis de Sade and the Chevalier von Sacher-Masoch. By JAMES CLEUGH. 295 pages including index. Cloth. Duell, Sloan and Pearce. New York. Little, Brown and Company. Boston. 1951. Price $4.50.

The subtitle of the book is inaccurate except insofar as chronicles of the Marquis de Sade and the Chevalier von Sacher-Masoch are basic material for study of the psychology of sex. Von Sacher-Masoch and de Sade are little more than names to most of us. Cleugh has compiled short and presumably accurate biographies which may serve to outline as personalities the two men for whom the algolagniac perversions have been named. These are not studies of their psychodynamics but are chronological sketches of their careers. The author notes that the source of material for the life of

one has not been exhaustively studied, and that in the other case it has not even been completely identified. The report is somewhat marred by Cleugh's occasional use of the fiction-biographical style in which thoughts or phrases, of which a modern biographer could not possibly be aware, are reported in quotation marks.

The lives thus recounted are of considerable general as well as professional interest. Both men were not without repute as literary personages in their days. The Marquis de Sade was a scion of one of the great aristocratic families of France of the *ancienne régime*. He was married to a woman of great wealth. As a prisoner in that fortress, he helped rouse Paris to the storming of the Bastille; he was an important leader on the popular side in the French Revolution; and he was a well-known novelist and playwright. He may, indeed, as Cleugh notes, have just missed being a great man. The Marquis de Sade wrote novels with horrifying mixtures of sex and cruelty; he was once arrested for an offense which seems to have involved sodomy; he certainly tortured his sexual partners; and he was once beheaded in effigy after a sentence by an apparently corrupt court, based on apparently worthless evidence. But his troubles seem to have been as much familial and political as criminal; the comparatively few instances of abnormality which were publicized to bring punishment or notoriety could in all likelihood have been paralleled in the lives of scores of his contemporaries; he was far from being the obvious monster which one tends to picture him. Given a little luck with the law, he might have passed unnoticed as a pamphleteering politician of today.

The Chevalier von Sacher-Masoch was a notable scholar and an international literary figure. It is true that he became psychotic before his death but for most of his life his career was not notably different from many another literary eccentric's. His writings, of course, disclosed his perversion; and it is interesting to note that when he became definitely psychotic the reverse of the medal appeared. His biographer is authority for the story that he threatened his family and killed a pet kitten at the time his demands that he be tortured were at their height.

De Sade also died in a mental institution but, according to Cleugh, was never psychotic. Modern institutional psychiatrists will be fascinated by the possibility that, during his incarceration, de Sade originated drama therapy. His idea probably was to amuse himself, but the improvement in the patients was notable, until the dramatic performances were forbidden by a humorless politician.

With full recognition of its drawbacks and its limitations, the reviewer considers Cleugh's book on these two important figures to be both informative and useful. It is certainly recommended reading for anybody interested in the general background of psychiatry.

Men, Women and Morals. By SYLVANUS M. DUVALL. 336 pages including index. Cloth. Association Press. New York. 1952. Price $3.75.

This is a painfully sincere book, obviously compiled with the most noble intentions. The author is a teacher of social science, familiar with scientific method, and his volume includes a 12-page bibliography, with titles ranging from Maxwell Anderson to L. M. Terman, Alfred Kinsey, Ben Lindsey, B. Malinowski, Havelock Ellis, Karl Menninger and Sigmund Freud. But in the introduction he says: "Scientifically speaking, sex is largely unexplored territory." Without disputing that amazing statement, it must be said that the present author adds little to the business of exploration. On page 295, one of his conclusions is: "A code which restricts sexual intercourse to marriage is morally defensible and workable in that it can be understood and can reduce considerably the amount of forbidden behavior. Or you can . . . demand complete permissiveness for everyone. . . . There is literally no other position in between which is either *reasonably workable* or ethically defensible." The italics are the reviewer's, who would like to know how Professor Duvall can reconcile this statement with his own authorities—as given in his bibliography.

This book is intended for general reading, but it certainly cannot be recommended as an example of good research or sound reasoning on an exceedingly difficult subject.

Communication: The Social Matrix of Psychiatry. By JURGEN RUESCH, M. D., and GREGORY BATESON. vi and 314 pages. Cloth. Norton. New York. 1951. Price $4.50.

The combination of an anthropologist and a psychiatrist in a study dealing with communication as it affects human living has great possibilities, and it is a pity that the resulting work is not better than it turns out to be. A sense of cohesiveness is lacking, and the authors find great difficulty in sticking to the subject at hand. The general approach is sympathetic to gestalt psychology, and many interesting points are made, but this reviewer found a tendency toward unwarranted generalizations, particularly in the section dealing with the "American Character." One may score this book, in the over-all picture, a "miss," but at the same time applaud the trend toward integration of different fields dealing with facets of human personality.

Miracle Father. By FRANCIS SYLVIN. 250 pages. Cloth. Metcalf Associates. New York. 1952. Price $3.00.

Miracle Father is a novel about artificial insemination, written with astounding lack of the most primitive knowledge of unconscious factors. The theme is interesting; the execution silly. The authors—"Francis Sylvin is the pseudonym of a collaborating team"—have reason to remain undisclosed.

Psychiatry and Medical Education. John C. Whitehorn, M. D., chairman, editorial board. 164 pages including index. Cloth. American Psychiatric Association. Washington, D. C. 1952. Price $1.00.

This is a report of a conference of psychiatrists and medical educators, conducted at Cornell in 1951 under the sponsorship of the American Psychiatric Association and the Association of American Medical Colleges. It is a highly selective, carefully written and edited, summary of the material discussed and the conclusions reached at the Ithaca meeting. An appendix lists the original documents, with prices for those (most of them) which are available in mimeographed form on application to the American Psychiatric Association.

The volume takes up the medical student, the setting of medical education, an extensive review of content and method in existing undergraduate psychiatric teaching, a discussion of the scientific foundation of psychiatry, problems of administration for psychiatric teaching and a discussion of the community and the physician. Outlines and recommended readings for teaching human ecology and personality are covered in a statement prepared by Dr. Norman Cameron, and reproduced in this volume. The editors note that it "received very general and enthusiastic approval at the conference. It is presented here as a detailed and specific formulation of the kind of basic knowledge needed by physicians." The reviewer thinks this small volume is necessary reading for anybody interested in the problem of undergraduate psychiatric education, or psychiatric education in general, and that it is indispensable background material for anybody who may be called upon to teach psychiatry at the undergraduate level, or to write upon, or discuss, the subject.

Master Your Mind. By SAMUEL KAHN, M. D., Ph.D. xxviii and 262 pages. Cloth. Rockport Press, Inc. New York City. 1950. Price $3.00.

Master Your Mind, by Samuel Kahn, M. D., Ph.D., is neither a valuable nor intelligent book. It is instead a hodgepodge of miscellaneous statements in haphazard chapters, only partly connected logically, without consistency or psychological insight. On careful review it suggests even unsound thinking and a not too logical viewpoint. The book re-hashes old ideas on the psychology of thought and memory, without even integrating them into a consistent or single pattern. Yet, it is interesting in a strange way, because it is written by a student of psychiatry who himself is almost deluded into thinking that is unclear and sometimes illogical, and certainly is without stability of viewpoint. It cannot be recommended on any count, because it lacks substance, an intelligent format, and enough sound thinking.

Trial of the Stauntons. The Penge Mystery. Second edition. Notable British Trials Series. J. B. Atley, editor. 327 pages with appendices. Cloth. William Hodge and Company, Ltd. London, Edinburgh, Glasgow. British Book Centre, Inc. New York. 1952. Price $3.25.

The trial of the Stauntons, three-quarters of a century ago, was notable for the disregard of medical evidence. A hanging judge and a jury, indignant at the adultery of two of the four defendants, would have sent them all to the gallows were it not for the British medical profession. Harriet Staunton's husband, his paramour, his brother and wife were convicted and sentenced for her murder by starvation—for the husband's monetary profit and his freedom to pursue a guilty love affair.

The executions were halted by a memorial signed by 700 physicians and surgeons, headed by Sir William Jenner, that the dead woman's symptoms indicated cerebral disease (probably tuberculous meningitis), not starvation. On re-examination of the evidence, one of the condemned was pardoned at once; two others were released after some years of imprisonment; the fourth, his sentence commuted to life, died in prison. The Staunton case is as fine an example as this reviewer knows of the difficulties of legally establishing scientific fact in the face of emotional prejudice. It is of particular application to forensic psychiatry where the sort of problem faced by the general medical men in the Staunton case is likely to be encountered in any psychiatric court issue whatever. It should be remarked that it should be of equal interest to the barrister confronted with the presentation or refutation of medical testimony.

Philosophy in a New Key. A Study in the Symbolism of Reason, Rite and Art. By SUSANNE K. LANGER. xviii and 302 pages. Cloth. Harvard University Press. Cambridge, Mass. 1951. Price $4.75.

Susanne K. Langer's *Philosophy in a New Key* is, as the subtitle indicates, a study in the symbolism of reason, rite, and art. Dedicated to Alfred North Whitehead, Mrs. Langer's volume deals comprehensively with the philosophic elements and factors in symbolic transformation, the logic of signs and symbols, language, the roots of sacrament and myth, the significance of music, the genesis of artistic import, the fabric of meaning, and all of the interrelationships and intrarelationships in the philosophy of living.

Philosophy in a New Key presents a study of human intelligence, beginning, in effect, with a semantic theory, and leading into the various facets of human interpretations of the arts of man. The book is, in its application, as related to literature, art, music, and semantics as it is to the broad field of philosophy and thought. The volume is effective, vigorous, and written in a clear and concise style. Mrs. Langer has a fine insight into the entire field of philosophy, which she synopsizes well in this subtly reasoned book.

The Sense of Shakespeare's Sonnets. By EDWARD HUBLER. 169 pages including index. Cloth. Princeton University Press. Princeton, N. J. 1952. Price $3.00.

Hubler discusses the sonnets from the point of view of the literary man who is interested in their manifest content rather than their value in disclosing the unconscious emotional conflicts of the poet. He does, however, touch on two matters of more than a little psychiatric interest: the question of the Baconians, whom Hubler dismisses in a devastating little essay as primarily moved by snobbishness; and the question of homosexuality. Hubler finds the sense and the personnae of the sonnets rather obvious. They express Shakespeare's relationship with three other persons, another poet, a young man and a young woman.

"The dark lady" is a lady, not a man, says Hubler; and, concerning the expressions of "love" which are directed to the young man as well as to the lady, Hubler points to the universal use of that word by the Elizabethans to mean friendship as well as the heterosexual love relationship. "This was the usage of the day," he says, adding, "there was also the Renaissance concept of the superiority of the friendship of man to man over the affection of man for woman." Hubler concludes that the sonnets show, among other things, Shakespeare's decision to prefer the young man's friendship to an affair with a lady who, to say the least, was a trollop.

Whatever may be the merits of this interpretation, the appeal to the language usage of the day deserves respectful attention from all investigators of Shakespearian psychodynamics. Hubler thinks it possible that Shakespeare was homosexual, but regards it as most unlikely. He points out: "In the most notable instance the charge has been made by men of known homosexual experience, who, like members of all minority groups, are anxious to increase their numbers." He points to impressive literary and other evidence, in the sonnets and elsewhere, of the poet's normal and vigorous heterosexuality.

Equality by Statute. Legal Controls Over Group Discrimination. By MORROE BERGER. 238 pages including index. Cloth. Columbia University Press. New York. 1952. Price $3.25.

Morroe Berger here reviews the social situation under existing federal and state laws against racial and religious discrimination. Almost half the volume concerns the present New York law prohibiting discrimination in the private employment field. The status of segregation, education and other civil rights elsewhere in the country is also carefully reviewed with particular attention to Supreme Court decisions since the Civil War. Concerning the question of whether legislation can be effective in this field, Berger finds that the New York State law has had a good effect.

Thinking and Valuing. An Introduction, Partly Historical, to the Study of the Philosophy of Value. By D. J. McCracken. ix and 238 pages. Cloth. Macmillan. London. 1951. Price $2.50.

D. J. McCracken, author of *Thinking and Valuing: An Introduction, Partly Historical, to the Study of the Philosophy of Value*, is a lecturer in philosophy in the University of Birmingham, England. He agrees with Socrates that "an unreflective life is not worth living." The central aim of this book is, in the author's words, "to clarify and support and illustrate with historical examples the philosophical thesis that value-judgments play an integral and essential part in the intellectual life of man." Mr. McCracken uses the verbal form, "valuing," as an analogy of "thinking" to denote the activities of forming value-judgments, of appreciating, estimating and evaluating.

Valuation, according to the author, is a process of creative discovery, necessary for intellectual as well as for moral and aesthetic fulfillment. And the author, as an educator as well as thinker, defines "an intelligible world" as a world in which not only scientific thinking but also rational practice are possible—to be sure, an idealistic, but certainly a significant, ideal. *Thinking and Valuing*, then, amounts to this, as a book: The general discussions are meant to clarify the hypothesis that reflective value-judgments occur and are intellectual acts, taking their material from experience, but grounded upon an *a priori* concept of category. The author tests this hypothesis against the intellectual constructions of Descartes, Geulinex and Spinoza. Mr. McCracken has produced a book that will both stimulate the general reader and induce students of the history of modern thought to re-think, even re-open, certain historical questions in the problem of thought.

The Witching Night. By C. S. Cody. 255 pages. Cloth. World Publishing Company. Cleveland. 1952. Price $2.75.

The dust jacket of this novel states it is the first work in a planned series on demonology and black magic. Avert the evil! A considerable amount of research in folklore and medicine, including psychiatry, has obviously been expended in this book. The subject is a fascinating one for all students of the mind; some brilliant fiction has occasionally been written on it.

To this reviewer, Mr. Cody's book does not seem to fall into the brilliant fiction class. Judgments in this field are necessarily most subjective; but to this reviewer at least, *The Witching Night* is a most unconvincing mixture of the gruesome and the sensual, neither well-grounded in the psychology of folklore nor in scientific psychology. He would call it adolescent, if not even more immature.

The Maggid of Caro. By HIRSCH LOEB GORDON, Ph.D., M. D., Litt.D., Sc.D. 396 pages. Cloth. Pardes Publishing House, Inc. New York. 1949. Price $4.00.

The mystic life of the eminent codifier, Joseph Caro, as revealed in his secret diary is fascinatingly portrayed in *The Maggid of Caro*, by Dr. Hirsch Loeb Gordon. Based on unpublished manuscripts, Dr. Gordon has reconstructed the life and thought of the Hebraic mystic and eminent codifier of laws and institutions, during the period of his life from 1488 to 1575. The book has obviously required much planning and research, and the end-product makes masterful and interesting literature, however spotty it is in places. The problem of the hallucinations of Caro is studied psychiatrically by the author, and from the volume comes forth another potent concept, that is, the concept of Maggidic hallucination—the intimate fears, hopes and ambitions of a genius who was at the same time a mystic with a kind of inner and familiar spirit with which he communicated; the activities of a mystic who set himself the task of uplifting and redeeming the world through a life of holiness and toil; in the hope that by example he would guide the thoughts and acts of man toward moral goals.

Dr. Gordon deals, with much insight, with the communications, the prophecies, the hypnagogic dream states, the "inner voices," the double personality, in short, the "Maggidism" of Joseph Caro, as defined psychologically and psychiatrically. The very dynamics of the man and mystic named Caro make not only fascinating reading but creative psychiatric evaluation; and *The Maggid of Caro* is recommended to those individuals who are fundamentally interested in religious realities, the power of anticipation, the paraphrenias, the asthenias, and, generally, the strangely phenomenalistic aspects of mysticism as applied to man.

Estimated World Requirement of Narcotic Drugs in 1952. 64 pages. Paper. Columbia University Press. New York. 1951. Price 60 cents.

This is an official UN estimate of world requirements for the principal narcotic drugs which are under international control by the protocol of November 1948. Estimates for countries and territories which supplied no estimates themselves are omitted by the supervisory body; and, concerning the Union of Soviet Socialist Republics and a number of Russian satelite states, the note is made that further information has been requested regarding the estimates given. This report is of interest to law enforcemnt authorities and to research workers in forensic medicine and in problems of addiction.

CONTRIBUTORS TO THIS ISSUE

WILLIAM L. HOLT, JR., M. D. Dr. Holt is chief of the psychiatric service at Albany Hospital, Albany, N. Y., and professor of psychiatry at Albany Medical College. Born in 1906, he was graduated from Harvard Medical School in 1932. He had a three-year residency in psychiatry at Boston Psychopathic Hospital and a residency in neurology at Massachusetts General Hospital, after which he joined the staff of Worcester (Mass.) State Hospital. After service in the navy in World War II, he became chief medical officer at Boston Psychopathic Hospital. He assumed his present positions in Albany last November.

LOUIS S. LONDON, M. D. Dr. London is in private practice in Washington, D. C., and New York City and is in practice as a consultant. He had had 15 years of experience on the staffs of a number of large psychiatric institutions in New York State when he decided to go to Vienna where he spent several years of postgraduate study in neurology, psychiatry and psychoanalysis. He has had his present practice for the last 25 years.

Dr. London is a diplomate of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association, a fellow of the American Medical Association, and a member of other professional societies. He is the author of a number of books and articles on psychiatric subjects.

FLOYD O. RING, M. D. Dr. Ring was graduated from the University of Nebraska College of Medicine in 1948. Following internship at Wayne County General Hospital, Eloise, Mich., he became a fellow of the Menninger Foundation School of Psychiatry and resident in psychiatry at the Winter Veterans Administration Hospital. He is an associate member of the American Psychiatric Association and a member of other professional groups. He was a member of the Lobotomy Research Group at Winter V. A. Hospital. At present, he is psychiatrist at the Nebraska Psychiatric Unit, department of adult psychiatry, and instructor in psychiatry at the University of Nebraska College of Medicine, Omaha, Neb.

DAVID COLE WILSON, M. D. David Cole Wilson, born in Chattanooga in 1892, was graduated in medicine from the University of Virginia in 1919. He has been professor of psychiatry and neurology there since 1937. Following internship at the University of Virginia, he had been on

the medical service of Peter Bent Brigham Hospital, Boston; and on the staff of Clifton Springs (N. Y.) Sanitarium, where he headed the department of neurology and psychiatry from 1923 to 1929 before returning to the University of Virginia.

Dr. Wilson is a fellow of the American Psychiatric Association and the American College of Physicians, and a member of other scientific and professional societies. He is the author of a large number of scientific articles on psychiatric and neurologic subjects. Dr. Wilson was married to Miss Elizabeth Jackson in 1921; they have four children and four grandchildren. He is a golfer, fisherman and hunter.

WLADIMIR G. ELIASBERG, M. D., Ph.D. Dr. Eliasberg is now in the private practice of psychiatry and neurology in New York City. Born in 1887 in Germany, he was graduated in medicine 40 years ago from the University of Heidelberg. He received his Ph.D. in psychology from the University of Munich in 1924. In 1926, he was founder and secretary of the German Medical Society of Psychotherapy, and from 1928 to 1930 was editor of the *Congress Reports* and of the *Allgemeine Aerztliche Zeitschrift für Psychotherapie*. He is the author of some 300 scientific publications in this country and abroad, including 10 books, and including more than 50 articles published in the United States. His special interests include: aphasia, forensic psychology, graphology and medicine, and the psychology and sociology of propaganda and advertising—on which last subject he was the author of three books published in Vienna and Prague in 1936. He has contributed to sociological and law journals as well as psychiatric. Dr. Eliasberg is a fellow of the American Psychiatric Association, is president of the Association for the Psychiatric Treatment of Offenders (New York) and a member of other professional and scientific societies.

SOL L. GARFIELD, Ph.D. Dr. Garfield has been chief clinical psychologist and director of the psychological training unit at the Veterans Administration Mental Hygiene Clinic, Milwaukee, since 1949. Born in Chicago in 1918, he received his Ph.D. from Northwestern University in 1942. He was already serving there as clinical psychologist of the Psycho-Educational Clinic, and he was a clinical psychologist in the army from 1942 to 1945. He was chief clinical psychologist at the Veterans Administration hospital, Mendota, Wis., in 1946 and 1947 and was associate professor of psychology and director of the bureau of psychological services at the University of Connecticut from 1947 to 1949, when he went to Milwaukee. He is the author of 15 published papers on topics related to clinical psychology in psychiatric and psychological journals.

MAX KURZ, M. A. Mr. Kurz, executive secretary of the Waukeshaw County Guidance Clinic, Waukeshaw, Wis., was formerly a psychiatric social worker with the mental hygiene clinic of the Veterans Administration in Milwaukee. Born in 1917 in Vienna, he had attended the University of Vienna Faculty of Medicine for three years before coming to the United States late in 1938. He served for four years in medical administration in the United States Army from 1941 to 1945. He received his bachelor's degree from the State University of Iowa in 1946 and his M. A. from the University of Chicago, School of Social Service Administration, in 1948. Besides his work with the Milwaukee Veterans Administration clinic, he has served as case worker in the boys' court service of the Church Federation of Greater Chicago, and as case worker in the Family Service of Milwaukee.

HENRY P. PECHSTEIN, M. D. Dr. Pechstein is a graduate of the University of Pennsylvania in 1942 and received his medical degree from Jefferson Medical College in 1945. He served as a lieutenant (j. g.) in the medical corps of the navy for two years and has been on the staffs of Norristown (Pa.) State Hospital and Hudson River (N. Y.) State Hospital. At present, he is a supervising psychiatrist at Pilgrim (N. Y.) State Hospital.

ALFRED T. BUTTERWORTH, M. D. A graduate in medicine from Louisiana State University in 1942, Dr. Butterworth is at present in private practice in New Orleans. He is a psychiatrist at Charity Hospital, and an instructor in psychiatry at Louisiana State University medical school. He interned at Baptist Hospital in Memphis, Tenn., and served as resident at the Veterans Hospital in New Orleans and at Springfield State Hospital in Sykesville, Md., from 1946 to 1950. He has been a student at the Washington School of Psychiatry in Washington, D. C.

LESTER E. SHAPIRO, M. D. Born in Brooklyn in 1914 and a graduate of Columbia College in 1933, Dr. Shapiro received his medical degree from the Royal College of Physicians and Surgeons of Glasgow and Edinburgh in 1940. He served a rotating internship at Gouverneur Hospital, N. Y., from 1940 to 1942, and was in the army medical corps from 1942 to 1945, the last two years serving as acting unit psychiatrist with an evacuation hospital. He served as resident, then as senior psychiatrist at Pilgrim (N. Y.) State Hospital from 1945 to 1948. He was formerly staff psychiatrist at Adelphi Child Guidance Center, Garden City, N. Y.

Dr. Shapiro began psychoanalytic training in 1948 and is now in private practice, specializing in psychoanalysis. He states that, nevertheless, he

is still very much interested in "the constructive potential of the mental hospital set-up." Dr. Shapiro is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and a member of other professional societies.

B. W. MURPHY, M. B., Ch.B. Dr. Murphy was born in Wellington, New Zealand, in 1921; he received his medical and surgical degrees from Otago University, New Zealand in 1944. He was senior intern and assistant resident at Allan Memorial Institute, Montreal, in 1947-1949, and was on the staff of the Crease Clinic and Provincial Mental Hospital, Essondale, B. C., for the following two years. He received his diploma in psychiatry from McGill in 1951. Dr. Murphy is at present a senior resident at the Seton Institute, Baltimore, and is undergoing psychoanalytic training at the Baltimore division of the Washington-Baltimore Psychoanalytic Institute. He has published scientific papers previously in other journals.

NORMAN C. RINTZ, M. D. Dr. Rintz is a graduate of Jefferson Medical College, class of 1931. He held a rotating internship at Delaware Hospital and, following residencies in pediatrics, medicine and surgery, was a general practitioner in western Pennsylvania from 1933 to 1948. He was psychoanalyzed in Pittsburgh in 1946-1947 and spent two years, 1948-1950, at Boston (Mass.) State Hospital in psychiatry. At present he is at Chestnut Lodge, Rockville, Md. He is a member of the American Medical Association and of the Boston Group for Advancement of Psychotherapy in Psychoses.

IRVING M. ROSEN, M. D. Dr. Rosen is a graduate of Boston University and received his medical degree there in 1945. Following two years of medical service at Boston City Hospital, he was trained in psychiatry at Boston State Hospital. At present he is in charge of the chronic female service there and also has a part-time psychiatric practice in Framingham and Boston. Dr. Rosen was psychoanalyzed in Boston and is on the faculty of Harvard Medical School, teaching in-patient psychiatry at Boston Psychopathic Hospital. He is interested in research in individual and group psychotherapy in the psychoses and has read and published papers in these fields (in *Psychiatry* and in *Diseases of the Nervous System*). He belongs to the American Psychiatric Association, the Massachusetts Society for Research in Psychiatry, and the Group for Advancement of Psychotherapy in Psychoses (Boston).

MAURICE R. GREEN, M. D. Dr. Green was born in Chicago. He attended college and medical school at Northwestern University, obtaining

his medical degree in 1946. He served a rotating internship at Passevant Memorial Hospital, and served in the U. S. Army as a neuropsychiatrist from 1946 to 1948. Since that time, he has completed his residency in psychiatry at the Veterans Administration Hospital in the Bronx, New York. He began psychoanalytic training at the William A. White Institute of Psychiatry in 1949 and is now continuing it. He has been clinical assistant at the Child Psychiatry Clinic at Roosevelt Hospital, New York City, since August 1950.

OSKAR GUTTMANN, M. D. Dr. Guttmann was graduated from medical school in Florence (Italy) in 1936. His doctorate thesis was in psychiatry, on the subject of "Mythomania," as he had interned at the Neuro-Psychiatric University Hospital of the Medical School in Florence.

Most of Dr. Guttmann's training and medical experience was received in the University Hospitals in the *Allgemein Krankenhaus* in Vienna, where he was a student of Prof. Dr. Ernst Lauda (internal medicine) and Prof. Dr. Otto Pötzl (neuropsychiatry). Between 1945-1947, he was in physiopathological research involving the Austrian version of the "iron lung" —the "biomotor," which was studied in the clinic of physical medicine of the First University Medical Hospital. Other studies there included problems in connection with cardiology, rheumatic diseases and psychosomatic medicine. Seven papers were published as a result; Dr. Guttmann's papers on "Neuroses of the Stomach" and "Acute Infection and Residual Madness" were sponsored by Prof. Pötzl.

Dr. Guttmann came to this country in 1949 and served a rotating internship at Barnert Memorial Hospital in Paterson, N. J., where he also worked in neuropsychiatry with Dr. Hans Wassing, former Viennese pathologist. Since 1950 he has been a resident in psychiatry at Binghamton (N. Y.) State Hospital.

MAURICE KLOTZ, M. D. Dr. Klotz is chief of the acute intensive treatment service at the St. Cloud Veterans Administration Hospital, St. Cloud, Minn. A biographical note on Dr. Klotz appeared in the January 1952 issue of THE PSYCHIATRIC QUARTERLY, in connection with the original paper, "Prefrontal Leukotomy: A Clinical Survey of 100 Cases Given an Active Retraining Program in a Mental Hospital," to which the short paper in the present issue is an addendum.

WALLACE P. RITCHIE, M. D. Dr. Ritchie is associate clinical professor of the department of surgery of the University of Minnesota and is consultant in neurosurgery at the Veterans Administration Hospital, St.

Cloud, Minn. A biographical note on Dr. Ritchie was published in the January 1952 PSYCHIATRIC QUARTERLY in conjunction with notes on Dr. Maurice Klotz and Dr. Burtrum C. Schiele.

BURTRUM C. SCHIELE, M. D. Dr. Schiele is professor of psychiatry and director of the psychiatric service at the University of Minnesota Hospitals, and is psychiatric consultant at the Veterans Administration Hospital, St. Cloud, Minn. A biographical note on Dr. Schiele appeared in the January 1952 QUARTERLY in conjunction with notes on Dr. Maurice Klotz and Dr. Wallace P. Ritchie.

NEWS AND COMMENT

SCHIZOPHRENIA RECOVERY RATE TRIPLES IN 30 YEARS

Rates of partial or total recovery from schizophrenia among first admissions to New York State mental hospitals rose from about 17 per cent in 1909 to 57 per cent in 1949, according to findings recently released by the New York State Department of Mental Hygiene. The availability of more skilled personnel to give increased attention and care is the key to improved recovery rates, according to a statement by Commissioner Newton Bigelow, M. D., of the New York State department. In the case of the figures cited here, the improvement is attributed largely to the introduction of the shock therapies. The New York figures further indicate that, taking all mental disorders into consideration, less than half of all present first admissions to New York State hospitals now remain in the hospital at the end of a year, and that, excluding those who die, 51 per cent are discharged within two years—usually after a year's convalescence in the community.

In comment based on the New York State figures, the National Association for Mental Health notes that there has been an increase throughout the country of about 20 per cent in mental hospital patients since 1940; that the present total is about 650,000, "as many as there are in all other hospitals combined"; and that annual first admissions are now 250,000 a year, with readmissions of 100,000 a year. In its release for the general public, the association cautions that this increase does not mean that mental disorder is increasing, but that the growth in population, increased life span and other factors must be taken into account. The association reported that there are about 680 mental hospitals in the United States, 97 per cent of them public institutions. The association noted continued understaffing and overcrowding, finding that no state hospitals reached the "minimum personnel" standards of the American Psychiatric Association.

COLORADO ANNOUNCES EXAMINATIONS

The Colorado State Civil Service Commission has requested publicity for an announcement of examinations for positions at Colorado State Hospital ranging from assistant superintendent and psychiatrist to chiefs of various services, anesthesiology, internal medicine, surgery and others. Requirements include eligibility for licensing to practise medicine in Colorado, graduation from an approved school and varying experience records. Applications close on August 30, 1952, and all examinations are to be given at Colorado State Hospital, Pueblo, Colo.

S. EUGENE BARRERA, M. D., IS DEAD AT 51

Dr. S. Eugene Barrera, former dean of the department of psychiatry at Albany Medical College, and for 16 years before his appointment at Albany a research psychiatrist and neuropathologist at the New York State Psychiatric Institute, New York City, died at Ellis Hospital, Schenectady, N. Y., on May 27, 1952, after a long illness. He was 51 years old.

Dr. Barrera had been head of the Albany Medical College psychiatry department since January 1944 until his resignation in July 1951 because of ill health. He had also been administrator of Mosher Memorial Hospital, the psychiatric division of Albany Hospital, and had been consultant in psychiatry and neurology for the upstate New York division of the Veterans Administration. Dr. Barrera had gone to Albany from the Psychiatric Institute, where he was principal research psychiatrist. He had joined the staff of the Institute for work in neuropathology 17 years before.

Born in Yonkers, Dr. Barrera received his undergraduate and professional education at Columbia University, where his medical degree was conferred in 1926. After a year of postgraduate work, he became affiliated with the Psychiatric Institute. In the course of his professional career, Dr. Barrera was the author of a large number of scientific articles on psychiatric and research subjects, many of which were published in THE PSYCHIATRIC QUARTERLY.

NEW QUARTERLY REVIEW APPEARS

The *Quarterly Review of Medicine*, succeeding the *Quarterly Review of Internal Medicine and Dermatology*, has published its first issue, as "Vol. 9, No. 1, February 1952," it is announced by the Washington Institute of Medicine. The new journal is edited by Dr. Emanuel B. Schoenbach, professor of medicine of the State University Medical Center at New York City, and director of medical services, Maimonides Hospital, Brooklyn. Under its new title, this journal publishes original articles and abstracts on all branches of medicine, including neurology and psychiatry, rather than a restricted field.

SYMPOSIUM ON SPEECH PROBLEMS SCHEDULED

A symposium on "Speech Problems of School Children," sponsored by two divisions of the American Psychological Association and three other interested societies, will be conducted in Washington, D. C., on August 31, 1952, preceding the annual psychological association convention from September 1 to September 6. G. W. Hartmann, chairman of the department of psychology, Roosevelt College, Chicago, and Frances A. Mullen, director of the bureau of mentally handicapped of the Chicago public schools, will be chairman of morning and afternoon symposium sessions respectively.

7 NEW YORK STATE APPOINTMENTS ANNOUNCED

Seven appoinments to high New York State Department of Mental Hygiene departmental and institutional positions, effective June 1 and July 1, 1952, have been made by Commissioner of Mental Hygiene Newton Bigelow, M. D.

Dr. Charles Buckman, assistant commissioner of the department, was named senior director of Kings Park State Hospital as of June 1, and Dr. James A. Brussel, assistant director of Willard State Hospital, was appointed to succeed him as assistant commissioner as of the same date. Dr. Brussel is in charge of the department's New York City office.

Dr. Henry Brill, director of Craig Colony, Sonyea, and Dr. Robert C. Hunt, director of St. Lawrence State Hospital, Ogdensburg, were named assistant commissioners as of July 1. Effective on the same date were appointments of Dr. Charles Greenberg, assistant director at Harlem Valley State Hospital, to succeed Dr. Brill as director of Craig Colony; Dr. George F. Etling, assistant director of Rome State School, to succeed Dr. Hunt as director of St. Lawrence State Hospital; and Dr. Duncan Whitehead, assistant director of Brooklyn State Hospital and acting editor of THE PSYCHIATRIC QUARTERLY, as director of Buffalo State Hospital. Dr. Arthur E. Soper retired as senior director of Kings Park State Hospital in April, Dr. Christopher Fletcher as director of Buffalo State Hospital in May, and Dr. H. Beckett Lang as assistant commissioner on June 1.

Biographical notes and portraits of the new assistant commissioners and directors will appear in a forthcoming issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT.

DR. OVERHOLSER IS FIRST WINNER OF ISAAC RAY AWARD

Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C., has been announced as the first winner of the American Psychiatric Association's Isaac Ray award, which is to be given annually for outstanding accomplishment in both psychiatry and jurisprudence. The recipient receives $1,000 and delivers a series of lectures at a designated university which has both medical and law schools. Dr. Overholser's lectures will be given some time next year at Harvard.

GROUP PSYCHOTHERAPY INSTITUTE SEMINARS ANNOUNCED

The Group Psychotherapy Institute, of which S. R. Slavson is president, has announced three seminars for the 1952-1953 academic year, each to run for 30 two-hour sessions, beginning in October. There will be a "survey seminar," one on activity group therapy with children, and one on analytic group therapy.

DR. FANNY VON HANN-KENDE IS DEAD AT 60

Dr. Fanny von Hann-Kende, New York City psychoanalyst and psychiatrist, died at Harkness Pavilion of the Columbia-Presbyterian Medical Center in New York on April 14, 1952 after a long illness. She was 60 years old. Born in Budapest, she received her medical degree in 1914 from the Royal Hungarian University and, for a number of years, specialized in pathology, teaching at the Royal Hungarian University. She became interested in psychopathology during World War I and underwent special training at the Wagner-Jauregg Clinic in Vienna from 1927 to 1929. Returning to Budapest, she became a member of Sandor Ferenczi's analytic group and developed her own method of what would now be called short psychotherapy. She lectured and taught psychoanalysis in Hungary from 1932 to 1936 and came to this country in 1938 to lecture at the invitation of the New York Psychoanalytic Institute. She became an instructor there in 1948 and, in the same year, became an associate in psychiatry at Columbia University and an associate attending at the university's psychoanalytic clinic for training and research.

CHARLES W. HUTCHINGS, M. D., DIES, AGED 52

Dr. Charles W. Hutchings, assistant director of Syracuse (N. Y.) State School, died in Syracuse on April 13, 1952 after a long illness. Dr. Hutchings was a veteran of both World Wars and had recently returned from more than a year's additional army service in Japan. A graduate of Syracuse University Medical College, he had been with the New York State Department of Mental Hygiene since 1926, with the exception of his military service. He was the son of the late Richard H. Hutchings, M. D., former editor of this QUARTERLY, former president of the American Psychiatric Association, and former superintendent of Utica and St. Lawrence (N. Y.) State hospitals.

DR. SAMUEL R. ROSEN DIES AT AGE OF 40

Samuel R. Rosen, M. D., widely-known New York City psychiatrist, director of the psychiatric clinic at the University Settlement House, consultant in psychosomatics at Goldwater Memorial Hospital and psychiatric consultant at Mount Sinai Hospital, died on May 24, 1952, at the Hospital for Joint Diseases in New York City, where he had been taken following a heart attack. He was 40 years old. Dr. Rosen, born in Massachusetts, was a graduate of Albany College of Medicine and a veteran of the second World War. He was the author of a number of scientific papers.

ARCHIBALD CHURCH, M. D., DEAD AT 91

Dr. Archibald Church, head a quarter of a century ago of the department of nervous and mental disease of Northwestern University, and a teacher, writer and professional figure of nation-wide repute, died in Pasadena, Calif., on May 8, 1952 at the age of 91. Dr. Church, chairman of Northwestern's nervous and mental disease department from 1900 to 1925, when he retired, gave $100,000 to the university in the latter year for endowment and maintenance of a medical library. He had been editor of the *Chicago Medical Record* and of a textbook on nervous and mental disease. In 1924, he attracted nation-wide attention when he was one of four psychiatrists called by the state to testify to the sanity of Nathan F. Leopold and Richard Loeb in their sensational trial for the murder of Robert Franks. He testified that neither was suffering from mental disease "of any nature whatsoever."

ARTHUR HASKING, M. D., AUTHORITY ON LEGISLATION, DIES

Dr. Arthur P. Hasking, psychiatrist and authority on laws relating to hospitalization and care of the mentally deranged, died in Jersey City, N. J., on May 28, 1952 at the age of 72. He had suffered a cerebral hemorrhage. Dr. Hasking, who received his medical degree from Columbia in 1903, was a member of the commission which revised the New Jersey laws for the care of the mentally ill in 1915. For 37 years before his death, he had been "adjuster" of Hudson County, the county's officer responsible for committing mentally ill, epileptic and tuberculous persons to state and county institutions. He had been Hudson County physician since 1939.

OCCUPATIONAL THERAPY ANNUAL CONVENTION

The American Occupational Therapy Association announces its thirty-fifth annual convention for August 9 to 16, 1952 at the Hotel Schroeder, Milwaukee, Wis. The general theme of the gathering is "Guideposts for Growth," and the convention chairman is Lucie Spence Murphy, O. T. R., of the *American Journal of Occupational Therapy*.

FIRST SAMUEL W. HAMILTON AWARD IS MADE

The American Psychopathological Association announces the establishment of the Samuel W. Hamilton Memorial Lecture and Award in recognition of the late Dr. Hamilton's contribution to psychiatry, medicine and sociology. The first award was presented to Clarence P. Oberndorf, M. D., clinical professor of psychiatry at Columbia, at the association's annual meeting, June 7, 1952. Dr. Oberndorf's memorial lecture was entitled "Function in Psychiatry."

THE AMERICAN JOURNAL OF MENTAL DEFICIENCY

RICHARD H. HUNGERFORD, *Editor*

APRIL 1952

TABLE OF CONTENTS

Price $7.00 per volume $2.00 a copy

Editorial Office—224 East 28 Street, New York 16, N. Y.
Richard H. Hungerford, M. A., *Editor*
Business Office—P. O. Box 96, Willimantic, Conn.
Neil A. Dayton, M. D., *Business Manager*

THE PSYCHIATRIC QUARTERLY

JULY 1932

Vol. 6 No. 3

TABLE OF CONTENTS

Special Departments